The Joint Legislative Executive Committee on Aging and Disability

September 25, 2013
Meeting Materials

- Agenda
- Overview: Joint Legislative Executive Committee on Aging and Disability Issues, Office of Program Research, Senate Committee Services
- A Review of Aging Taskforces: Common Recommendations, Evidence-Based Programs, and Available Resources, Megan Mulvihill, Intern, Office of Program Research
- DSHS: Long Term Care (presentation), James Kettel, Office of Program Research; Carma Matti-Jackson, Senate Committee Services; Ryan Black, Office of Financial Management
- DSHS: Long Term Care, Service Overview, James Kettel, Office of Program Research; Carma Matti-Jackson, Senate Committee Services; Ryan Black, Office of Financial Management
- Long Term Services and Supports in Washington State: Population Forecasts and Client Characteristics, David Mancuso, PhD, Research and Data Analysis Division, Department of Social & Health Services
- Inventory of Resources, Bea Rector, Home and Community Services Division, Department of Social & Health Services
- Health Care Authority Initiatives, MaryAnne Lindeblad, Health Care Authority
- Health Homes and Duals Financial Alignment Projects, MaryAnne Lindeblad, Health Care Authority
- Governor Inslee's Aging Summit Recommended Pre-Reads & Resources, Jason McGill, Office of the Governor

Washington State Legislature

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Joint Legislative Executive Committee on Aging and Disability

Wednesday
September 25, 2013
10:30 a.m.

Senate Hearing Rm 4
J.A. Cherberg Building
Olympia, WA

AGENDA

1. Introductions, overview of the Committee, and selection of chairs.
   - Christopher Blake, Office of Program Research

2. Aging 101: Information regarding state services for the aging population, including funding and demographic data.
   - James Kettel, Office of Program Research
   - Carma Matti-Jackson, Senate Committee Services
   - Ryan Black, Office of Financial Management

3. Progress of Department of Social and Health Services and Health Care Authority initiatives to inventory long-term care resources and demographic data.
   - David Mancuso, Department of Social and Health Services
   - Bea Rector, Department of Social and Health Services
   - MaryAnne Lindeblad, Health Care Authority

4. Overview of the upcoming Governor's Aging Summit.
   - Ingrid McDonald, AARP Washington
   - Jason McGill, Governor's Policy Office

5. Public testimony.

Joint Legislative Executive Committee on Aging and Disability Issues

The Joint Legislative Executive Committee on Aging and Disability Issues was established in the 2013-15 operating budget. Section 206 of the budget specifies the membership, responsibilities, and reporting requirements of the Committee.

Committee Leadership:
Co-chairs are to be selected at the Committee's first meeting from the members who are legislators.

Committee Membership:

- House of Representatives:
  - Rep. Harris, Rep. Jinkins, Rep. Johnson, Rep. Tharinger
- Senate:
  - Sen. Bailey, Sen. Darneille, Sen. Keiser
- Executive Branch:
  - Member from Office of the Governor (Jason McGill)
  - Secretary of the Department of Social and Health Services (Kevin Quigley)
  - Director of the Health Care Authority (Dorothy Teeter)
  - Director of Department of Retirement Systems (Marcie Frost)

Scope of Work:
Identify strategic actions to prepare for the aging of Washington's population by:

1. Establishing a profile of Washington's older population and population with disabilities and a projection of those populations through 2030;
2. Establishing an inventory of services and supports from health care and long-term services and supports;
3. Identifying budget and policy options to effectively use public resources to reduce the growth rate in state expenditures compared to current policies;
4. Identifying strategies to better serve the health care needs of the aging population and people with disabilities and promote healthy living;
5. Identifying options for financing mechanisms for long-term care services and supports to promote additional private responsibility to meet needs for services.
6. Identifying options to promote financial security in retirement, support people staying in the workforce, and expand the availability of workplace retirement savings plans; and
7. Identifying options to help communities adapt to the aging demographic in planning for housing, land use, and transportation.

Reports:

- Interim Report: December 10, 2013
- Final Report: December 10, 2014

Prepared for: Joint Legislative Executive Committee on Aging and Disability Issues
Prepared by: Committee Staff
Date: September 11, 2013

A Review of Aging Taskforces

Common Recommendations, Evidence-Based Programs, and Available Resources

Megan Mulvihill

OPR Public Affairs Intern & MPA candidate (University of Washington)

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Introduction

As the baby boomer generation starts retiring, many city, county, state, and federal governments; non-profit organizations; and international agencies have decided to address the issues of an aging population by assigning a task force to review the problems and report back recommendations. This memorandum has reviewed a handful of those task forces at different government levels and summarized their common issues and general recommendations. Many of the task forces looked at for this memorandum were focused on specific topics such as long-term care, elder abuse, employment, or housing while some were broad and overarching. In some cases, the task forces have specific action plans and concrete objectives, and a few have based their recommendations on evidence-based or best practice programs.

The major issue areas addressed by these task forces on aging included health and healthcare, lack of information and education about older adult services, elder abuse, lack of transportation, housing issues, caregiver stress, care management, lack of community engagement, older adult unemployment, and lack of continuing education opportunities.

Many common recommendations included disseminating information about services, increasing daily physical exercise, education about better nutrition and chronic diseases, protecting vulnerable seniors from all forms of abuse, increasing transportation services, allow for zoning changes and establish universal design features in homes to make it easier to age in place, increasing respite services for caregivers, promoting civic participation, and promoting re-training and lifelong education.

This memorandum will introduced common concerns and issues that were identified by the task forces, present a chart of common, generalized recommendations categorized by issue area, and then provide some specific examples and concrete action steps pulled from the task forces' reports. In addition, the memorandum will explain evidence-based programs versus best practices programs with nationally recognized examples. Lastly, included is an annotated bibliography of the task forces' reports and corresponding web links.

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Common Concerns and Issues Identified by the Task Forces

Listed below are the seven areas that were most commonly identified by the task forces as being the areas of greatest concern for an aging population. The bulleted lists include common issues for each topic area.

1. Information and Education about Services in all areas

   Almost every task force found a lack of easily accessible information about the types of services offered to older adults. This included general information and specific information for each topic area such as healthcare and housing. In general, public education about older adult services and programs was often identified as insufficient.
   - Information not easily accessible for older adults
   - General public unaware of older adult services

2. Health and Health Care

   Older adults often identify access to affordable health care as a concern because they are at greater risk of suffering from chronic and acute diseases. In addition, many task forces noted that too few older adults receive the daily exercise and nutrition they need which could prevent diseases, falls, and unnecessary health care costs.
   - Decreasing health and mobility
   - Chronic Illness/Disease
   - Cost of health care
   - Access to health care
   - Lack of physical exercise or activity
   - Poor nutrition
   - Lack of easily accessible healthy meals or foods

3. Elder Abuse (Physical, Emotional, and Financial)

   About half of the task forces' reports mentioned preventing elder abuse of all kinds: physical abuse, emotional abuse, neglect, and financial abuse and exploitation. The Michigan Task Force on Elder Abuse referred to it as "a mostly unrecognized and unreported social problem."
   - Vulnerable seniors
   - Underreporting of abuse
   - Decentralized and incomplete methods for reporting abuse
   - Inconsistencies in elder abuse definitions, reporting, and legal matters
   - Caregiver stress resulting in abuse
   - Lack of awareness about financial scams and exploits

4. Transportation

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Transportation was cited as a problem because as people grow older, they often lose their ability to drive and with that their independence or capacity to age in place. Transportation was often mentioned in conjunction with community planning and housing issues.

- Service gaps
- Lack of affordable transportation and transportation choices
- Lack of transportation near housing and other needed services

5. Housing

Housing was the second most mentioned problem identified by the task forces. Many cities, counties, and states want to promote older adults to "age in place". The CDC defined "'aging in place' as the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level." However, the task forces recognized the problems with zoning and building codes, community layouts and livability, in home care, and rising home costs as barriers to older adults aging in place.

- Lack of affordable housing and rising costs
- Lack of community planning for an aging population
- Struggle for older adults to age in place
- Houses are not build or structured for elderly inhabitants
- Zoning ordinances create a barrier for shared housing, grannie flats, and livable communities

6. Care Management, Caregiving, and Long-term Care

As older adults age they need more living assistance and medical care, and many of the task forces identified the capacity strain the baby boomers would create as a problem. In addition, many of the task forces believed that informal caregivers often do not have the support they need, and as a result, have high levels of unhealthy stress.

- Caregiver stress
- Need to increase resources and access to information about respite services
- Lack of education about the effects of caregiving
- Not enough employer flexibility for informal caregivers
- Shortage of long-term care workers and care managers
- Capacity shortages to handle the future demand for long-term care
- Lack of long-term care choices
- Need higher quality and more affordable long-term care

7. Employment, Community Engagement, and Education

Recognizing that older adults want to stay engaged in their communities and remain social after they retire, some of the task forces decided to address the lack of opportunities for older adults. This included a range of volunteer activities, lifelong learning opportunities, social and recreational activities, and employment opportunities. A few of the task forces decided to focus on the lack of re-training or job training for older adults who want to rejoin or remain in the workforce.

- Few employment opportunities for older adults

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- Not utilizing older adults as resources
- Few continuing education opportunities
- Not enough community engagement opportunities

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Chart of Common Recommendations	Washington	California	Michigan	Minnesota	Colorado	Hawaii	Oregon	Connecticut	Clark Co, WA	Snohomish Co, WA	Dane Co, WI	Orange Co, NC	Williamsburg, VA	Maturing of America	Center for Housing Policy	Aging of the American Workforce
Disseminating Information & Educating the Public About Services	●	●	●	●	●		●	●	●	●	●	●	●	●		●
Single point of access for information			X	X			X							X		
Make information more accessible			X	X			X	X		X		X		X		
Marketing strategies	X		X		X		X	X	X	X		X				X
Raise awareness about services	X	X	X	X	X		X	X	X	X	X	X				X
Health and Healthcare	●	●			●	●	●	●	●	●	●	●		●		
Regular physical activity/exercise		X			X	X	X			X	X	X		X		
Utilize evidence-based programs	X	X			X	X	X					X				
Fall prevention programs	X	X			X		X				X	X				
Nutrition education								X	X	X	X			X		
Access to nutritious meals					X	X	X	X	X		X	X		X		
Chronic disease management	X					X	X					X				
Access to preventative healthcare					X		X			X		X		X		
Specialized training for first responders	X					X			X	X	X			X		
More recreational facilities							X		X			X		X		
Mental and behavioral services						X	X		X		X	X				
Elder Abuse (Physical, Emotional, and Financial)			●		●	●	●	●		●	●	●	●			
Train healthcare professionals to recognize signs of elder abuse			X				X									
Define/standardize "elder abuse"							X	X								
Increase elder abuse reporting			X				X			X						

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Standardize reporting mechanisms			X		X		X	X								
Enlist financial institutions to become frontline responders of financial abuse			X					X			X					
Transportation						●	●	●	●	●	●	●		●		
More transportation services and options							X	X	X	X	X	X		X		
Expand volunteer driver services						X	X	X	X		X	X				
Install larger, easier-to-read road signs									X		X			X		
Improve license renewal procedures and driver assessments							X				X			X		
Housing	●				●	●	●	●	●	●	●	●	●	●	●	
More affordable housing options							X		X	X	X	X			X	
Preserve affordable housing							X		X			X			X	
Establish zoning changes							X	X	X		X	X		X	X	
Create universal design features/home modifications						X	X	X	X		X	X		X	X	
Promote aging in place	X				X	X	X	X	X		X			X	X	
Community planning for an aging population	X						X		X	X	X	X	X	X		
Tax incentives and property tax relief	X						X	X			X	X		X	X	
Care Management, Caregiving, and Long-Term Care	●			●	●	●	●	●	●		●	●				
Promote stress management programs for caregivers									X							

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Increase caregiver respite services	X			X	X	X	X		X			X				
Disseminate information about services	X			X			X		X		X					
Support informal caregivers	X			X		X			X		X					
Increase training for caregivers/managers				X		X	X	X			X					
Recruit a long-term care workforce	X			X			X	X			X	X				
Increase flexibility at the workplace for informal caregivers							X		X							
Employment, Community Engagement, and Education					•				•	•	•	•	•	•		•
Promote older adult civic participation									X	X	X	X		X		
Utilize older adult volunteers									X		X			X		
Promote job training and re-training					X				X		X	X		X		X
Entice boomers to remain in the workforce									X	X	X			X		X
Promote lifelong learning opportunities											X	X		X		
Encourage employers to utilize retirees who re-enter the job market											X	X		X		X
Promoting community engagement						X			X	X	X	X		X		

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Examples of Specific Recommendations by Issue Area

Disseminating Information and Educating the Public about Services

- Determine which communication strategies are preferred by older adults and determine a marketing plan based on information gaps that are identified (Orange County).
- Encourage development of an annual Senior Resource Guide (Clark County).

Health and Health Care

- Develop a healthful food store incentives program (Clark County).
- Make oral health services available to low-income and rural older adults and those who participate in nutrition programs (Colorado).

Elder Abuse

- Create limits on liquid assets that a guardian may control (Michigan).
- Promote a centralized toll-free number to report abuse (Michigan).
- Communities should offer education and training for older adults about how to protect themselves against financial fraud and predatory lending (Maturing of America).

Transportation

- Expand existing public transit schedules to improve weekend transportation options, especially at midday (Orange County).
- Continue to add shelters, benches and seat, landing pads, and other amenities to transit stops as funds are available (Clark County).
- Communities should offer driving assessment and training to help older adults remain on the road as safely as possible for as long as possible. Communities should also consider improvements to roadway design such as large print road signs, grooved lane dividers, dedicated left turn lanes, and extended walk times at pedestrian crosswalks to accommodate older drivers and pedestrians (Maturing of America).

Housing

- Property tax relief programs for low-income and age eligible households (Housing an Aging Population).
- Define "family" broadly when establishing zoning regulations for "single-family" homes to allow for accessory housing units, in-law apartments, and stand-alone units on a family member's property (Connecticut).
- Require government-subsidized housing to incorporate universal design principles (Housing an Aging Population).
- Concentrate new housing near employment, shopping, healthcare, transportation, and other services (Clark County).
- Naperville, IL removes snow from driveways of older residents and Laredo, TX provides smaller garbage receptacles for elderly upon request (Maturing of America).

Care Management, Caregiving, and Long-term Care

- Expand tuition credits and loan forgiveness options, and develop a program similar to the GI Bill for health and long-term care workers (Minnesota).

- Encourage community organizations and faith-based organizations to offer more respite services (Orange County).
- Encourage middle and high school students to work and volunteer in health and long-term care settings (Minnesota).
- Greater workplace flexibility for informal caregivers including:
    - Relocation of an employee may include moving an older family member too and resources need to be available to do this (Dane County).
    - Encourage employers to provide onsite adult day care facilities for employee's family members (Clark County).

Employment, Community Engagement, and Education

- Advertise lectures, continuing education classes, and resources offered at the Senior Centers, libraries, and other community locations (Clark County).
- Facilitate self-employment for older workers such as replicating Project GATE (Aging of the American Workforce).
- Communities should promote employment options-such as part-and flex-time work options-and to attract and retain an aging workforce (Maturing of America).

Evidence-Based and Best Practice Programs

Many task forces supported their recommendations with evidence-based programs. These are programs that recommend ways for older adults to maintain their health, stay active, and help prevent chronic diseases. The programs focus on physical activity, nutrition, and falls prevention. To be considered evidence-based, the program has to have undergone extensive research and randomized controlled studies in which evidence demonstrates the program is effective in improving the health of older adults and preventing chronic diseases. The following examples were taken from the *Evidence-Based & Best Practice Programs for Healthy Aging, Caregiving, and Care Transitions* by the Aging and Disability Resource Connection (ADRC) of Oregon.[1]

Examples of evidence-based programs:

Chronic Disease Self-Management

- **Living Well** is Stanford University's Chronic Disease Self-Management Program. It is a six week workshop that provides tools for living a healthy life with chronic conditions such as diabetes, arthritis, asthma, and heart disease. The workshop provides support for normal daily activities and dealing with the emotions chronic conditions can cause. The program also includes:
    - Positive Self-Management Program for people with HIV
    - Diabetes Self-Management Program specifically for people with diabetes
    - Chronic Pain Self-Management Program
    - Better Choice, Better Health, and an on-line version of the workshop.

  http://patienteducation.stanford.edu/.

[1] http://www.oregon.gov/DHS/spwpd/sua/docs/evd-bsd-pract.pdf.

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- **National Diabetes Prevention Program** is a lifestyle change program that significantly reduces the risk of developing type II diabetes among people at high risk. Participants work with a lifestyle coach in a group setting to make modest and attainable behavior choices. The intervention lasts one year, including 16 weekly sessions and six monthly post-core sessions.
- www.cdc.gov/diabetes/prevention/about.htm.

Physical Activity and Falls Prevention

- **Active Living Every Day** is a program developed by the Cooper Institute and Human Kinetics. It is 12 weeks, and self-paced to help people with sedentary lifestyles become and stay physically active. The course can be offered in a group or one-on-one format.
www.humankinetics.com/ppALP

- **Arthritis Foundation Exercise and Aquatics Programs** offer low-impact exercises that can be done either sitting or standing to help relieve stiffness and pain and to build strength and stamina. Classes meet 2-3 times per week for at least eight weeks. The programs were developed specifically for people with arthritis or related conditions, but are also appropriate for other frail or deconditioned older adults.
www.arthritis.org/exercise.php.

- **Fit and Strong** was developed by the University of Chicago as a physical activity program for older adults with arthritis designed to be offered three times per week for eight weeks. Each session includes a 60-minute exercise program and a 30-minute education and group problem-solving session to help participants develop ways of incorporating exercise into their daily lives.
www.fitandstrong.org.

- **Healthy Moves for Aging Well** was developed by the Partners in Care Foundation in collaboration with other Southern California organizations. This physical activity program is offered one-on-one to home-bound frail, high-risk sedentary older adults. The program was designed to be supported by case managers as an additional service of their community-based case management program.
www.picf.org/landing_pages/22,3.html

- **Matter of Balance (MOB)** was adapted from Boston University Roybal Center by Maine's Partnership for Healthy Aging. This community workshop teaches practical coping strategies to reduce the fear of falling. The group-based course is led by trained lay leaders over eight weekly two-hour sessions.
www.mainehealth.org/mob

- **Otago Exercise Program** is an individually tailored falls prevention exercise program that is delivered in participants' homes. A trained physical therapist provides four home visits followed by phone support and a booster session. Exercise includes a series of leg-strengthening, balance-retraining exercises, and a walking plan that get progressively more difficult.
www.acc.co.nz/preventing-injuries/at-home/older-people/information-for-programme-providers/index.htm#P42_2959.

- **SAIL (Stay Active & Independent for Life)** is a strength and balance fitness class developed in Washington for older adults that includes education on preventing falls. The classes meet three times per week for an hour. Exercises can be done seated or standing and include moderate aerobic, strength, and stretching exercises. Instructor training is available in-person or online through Pierce College.
  www.synapticseminars.com.

- **Strong For Life** was developed by Boston University. This six-week home-based exercise program increases strength, balance, and overall health. Volunteer coaches instruct frail homebound participants on how to exercise using an exercise video and monitor their performance.
  www.ncoa.org/improve-health/center-for-healthy-aging/strong-for-life.html

- **Tai Chi Moving for Better Balance** was developed by the Oregon Research Institute in Eugene. This simplified, eight-form version of Tai Chi, offered in community settings, has been proven to decrease the number of falls and risk of falling in older adults. Classes meet two to three times per week for at least three months. Program outcomes include decreased falls, and a decrease in fear of falling. A two-day instructor training is offered in the Eugene area, and occasionally in other areas of the state with support from the DHS Public Health Division.
  www.ori.org

- **The Arthritis Foundation Walk With Ease Program** is a community-based physical activity and self-management education program. It is conducted in groups of 12-15 people led by trained leaders in a structured six-week program. One-hour sessions are held three times a week over the six-week period for a total of 18 sessions. While walking is the central activity, Walk with Ease also includes health education, stretching and strengthening exercises, and motivational strategies. Group sessions include socialization time, a brief scripted pre-walk informational lecture, warm up and cool down, and a 10-35 minute walking period. Walk with Ease was specifically developed for adults with arthritis who want to be more physically active, but is also appropriate for people without arthritis, particularly those with diabetes, heart disease and other chronic conditions, who want to get more active. Instructor training is offered on-line.
  www.arthritis.org/walk-with-ease.php,

Medication Management

- **HomeMeds program** (formerly called the Medication Management Improvement System or MMIS) was adapted from the Vanderbilt University Medication Management Model by the Partners in Care Foundation in California. This intervention is designed to enable case managers, social workers and nurse case managers to enter a participant's medication into a computer-based alert system, and to resolve identified medication problems with involvement of a consulting geriatric pharmacist.
  www.homemeds.org

Depression and Mental Health

- **Brief Intervention and Treatment for Elders (BRITE)** was developed in Florida with support from SAMHSA, this program modifies the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model specifically for use with older adults with substance misuse or abuse. The program helps people age 55+ to identify nondependent substance use or prescription medication issues, and to provide effective service strategies that can prevent substance abuse. http://brite.fmhi.usf.edu

- **Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)** is designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. This case manager-led program typically lasts for 3-6 months. It was developed by the Huffington Center on Aging at Baylor College of Medicine, Sheltering Arms and the Care for Elders Partnership in Houston. http://careforelders.org/default.aspx/MenuItemID/290/MenuGroup/Initiatives+%26+Tools.htm

- **PEARLS** is a time-limited and participant-driven program that teaches depression management techniques to older adults with minor depression or dysthymia. It is offered to people who are receiving home-based services from community services agencies. The program consists of in-home counseling sessions followed by a series of maintenance session contacts conducted over the telephone. Community-based depression care managers use problem-solving treatment, social and physical activity planning, and pleasant events in a series of eight 50-minute sessions over a 19-week period with 3-6 subsequent telephone contacts. www.pearlsprogram.org

Alzheimer's and Caregiving

- **Community Stress-Busting Program for Family** Caregivers is a nine-week community workshop to improve the quality of life of family caregivers providing care for people with Alzheimer's disease or other dementias. Developed at the University of Texas, the program uses two trained facilitators to conduct the weekly 90-minute sessions. www.caregiverstressbusters.org

- **New York University Caregiver Initiative** is a six month counseling and support intervention for spouse caregivers that is intended to improve the well-being of caregivers and delay the nursing home placement of patients with Alzheimer's disease. The program uses social workers or mental health providers to provide individual and family counseling sessions, support groups, and follow-up counseling and phone support. http://nrepp.samhsa.gov/ViewIntervention.aspx?id=74

- **Powerful Tools for Caregivers** is a six-week education program developed by Legacy Caregiver Services, focuses on the needs of the caregiver, and is for family and friends who are caring for older adults suffering from stroke, Alzheimer's, Parkinson's disease or similar long-term conditions. The class provides participants with the skills and confidence you need to better care for yourself while caring for others. www.powerfultoolsforcaregivers.org/

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- **REACH II (Resources for Enhancing Alzheimer's Caregiver Health)** is a six-month multi-component home and phone-based intervention provided by case managers for Alzheimer's family caregivers. The intervention is designed to reduce caregiver burden and depression, improve caregivers' ability to provide self-care, provide caregivers with social support, and help caregivers learn how to manage difficult behaviors in care recipients.
http://nrepp.samhsa.gov/ViewIntervention.aspx?id=129

- **RDAD (Reducing Disability in Alzheimer's Disease**) was developed at the University of Washington; this program encourages exercise and problem-solving to help reduce depression among adults with dementia and their family caregivers. The program uses trained consultants to provide approximately 12 one-hour home visits over a 12-week period.
www.aoa.gov/AoA_Programs/HPW/Alz_Grants/reducing.aspx

- **Savvy Caregiver** is a 12-hour training program usually delivered in two-hour sessions over a six-week period. Developed at the University of Minnesota, the program focuses on helping caregivers think about their situation objectively and providing them with the knowledge, skills, and attitudes they need to manage stress and carry out the caregiving role effectively. Research has demonstrated significant positive outcomes regarding caregivers' beliefs about caregiving, their reactions to the behavioral symptoms of their care recipient, and their feelings of stress and burden.
www.rosalynncarter.org/caregiver_intervention_database/dimentia/savvy_caregiver/

- **STAR-C** was developed by the University of Washington's School of Nursing Northwest Research Group on Aging. The STAR-Caregivers (STAR-C) program is a home-based behavioral intervention to decrease depression and anxiety in individuals with Alzheimer's disease and their family caregivers. It consists of eight weekly hour-long in-home sessions followed by four monthly telephone calls.
www.aoa.gov/AoA_Programs/HPW/Alz_Grants/star-c.aspx

- **Tailored Caregiver Assessment and Referral (TCARE) Model** is an evidence-based caregiver assessment and referral tool used to tailor support and services unpaid caregivers receive to their unique needs. The screening and assessment process helps caregivers identify if they are at high risk for stress and depression, provides support and guidance, and helps caregivers create an individualized plan to meet their goals and needs while identifying available resources that best meet the caregiver's needs.
http://www.aasa.dshs.wa.gov/Professional/TCARE/documents/TCARE%20Fact%20Sheet.pdf.

Care Transitions

- **Bridge Program** is a hospital-based 30-day intervention that uses a trained social workers to provide a hospital visit and follow-up phone visit and phone support linked to aging services in the hospital and community.
www.transitionalcare.org/the-bridge-model/

- **Care Transitions Intervention** was developed by Eric Coleman. This four-week community or hospital-based intervention uses trained "transition coaches" to do a hospital visit, home visit,

and three follow-up phone calls addressing four pillars: use of a patient medical record, medication reconciliation, knowledge of red flags or warning signs, and follow-up with a primary care provider.
www.caretransitions.org

- **Guided Care** was developed by Chad Boult. This primary care based program uses a nurse to provide in-home assessment, care planning, self-management support, and support for care transitions for older adults with complex health conditions.
  www.guidedcare.org

- **GRACE (Geriatric Resources for Assessment and Care of Elders)** is an ongoing primary care-based intervention that that uses a social worker, nurse practitioner, interdisciplinary team, and clinical protocols addressing common geriatric conditions to improve quality of care and effective care transitions. The program is designed to improve the quality of geriatric care so as to optimize health and functional status, decrease excess healthcare use, and prevent long-term nursing home placement.
  http://medicine.iupui.edu/IUCAR/research/grace.aspx

- **Project BOOST (Better Outcomes for Older Adults through Safe Transitions)** is a hospital-based intervention that is designed to identify high-risk patients on admission, and reduce 30 day readmission rates. The intervention uses risk assessment tool, patient records, a teach-back process, and risk-specific interventions and discharge processes.
  www.hospitalmedicine.org/BOOST/

- **Transitional Care Model** was developed by Mary Naylor. This one to three month intervention uses a transitional care nurse to provide hospital and home visits, participation in a follow-up physician visit, and telephone support.
  www.transitionalcare.info/

Best practice programs are different from evidence-based because they have not undergone rigorous evaluation, but they are based on existing research that demonstrates effective methods. Below are some examples of best practice programs:

Examples of Best Practice Recommendations

Chronic Disease Self-Management

- **Healthy Changes for Living With Diabetes** was developed by Providence Center on Aging in Portland. This ongoing program uses trained volunteer group leaders and a defined curriculum assist older adults in the day-to-day self-management of Type II diabetes by focusing on diet and physical activity during weekly group meetings.
  www.ncbi.nlm.nih.gov/pubmed/19075087

Physical Activity and Falls Prevention

- **Arthritis Foundation Tai Chi Program** was designed for people with arthritis, this 12-movement Sun-style Tai Chi program was developed by Paul Lam and is supported by the Arthritis Foundation.
  www.arthritis.org/tai-chi.php

- **Better Bones & Balance** is based on research at Oregon State University's Bone Research Laboratory. This strength and stepping exercise class is designed to reduce the risk of osteoporosis-related fractures. Outcomes include improved strength, balance and mobility, and reduced bone loss.
  http://extension.oregonstate.edu/physicalactivity/bbb

- **Healthy Lifestyles** is a three-day health promotion intervention for people with disabilities developed by the Oregon Office on Disability and Health (OODH) at Oregon Health & Science University. The workshop is offered in English and Spanish by OODH through Oregon's Independent Living Centers. Healthy Lifestyles uses an integrated wellness and empowerment approach and provides participants with knowledge and skills to adopt healthy behaviors.
  www.ohsu.edu/oidd/oodh/HL/index.cfm

- **Strong Women** is a group strength-training exercise program developed at Tufts University and designed for midlife and older women. Outcomes include increased strength, improved bone density, improved health and self-confidence.
  www.strongwomen.com/

Healthy Eating

- **Eat Better Move More** is a 12-week program developed for congregate meal program participants, and usually led by individuals with a nutrition background. Weekly 30 minute sessions provide basic activity and nutrition education and encourage participants to be physically active and eat a more healthy diet. A second 12-week series is available for sites that have completed the first series.
  http://nutritionandaging.fiu.edu/You_Can/index.asp

- **Healthy Eating for Successful Living in Older Adults** was developed by the Lahey Clinic in collaboration with other Boston-area organizations. This is both an education and support program to assist older adults in self-management of their nutritional health. The workshop is conducted over six weekly two-and-a-half hour sessions with a peer leader and a RD/nutritionist resource person.
  www.ncoa.org/improve-health/center-for-healthy-aging/healthy-eating-for-successful.html

- **Eat Smart, Live Strong** is a program designed to improve fruit and vegetable consumption and physical activity among low-income able-bodied 60-74 year olds who are eligible for SNAP or other publically-funded nutrition programs.
  http://snap.nal.usda.gov/resource-library/nutrition-education-materials-fns/eat-smart-live-strong

Care Transitions

- **Project RED** is also known as the Re-Engineered Discharge. This hospital-based program works with patients to organize post-discharge plans, follow-up visits, and patient understanding of their condition, medications, and warning signs.
  www.bu.edu/fammed/projectred

Annotated List of Resources

Below is a list of the task forces that had more comprehensive policy recommendations and specific action steps. These task forces covered a wide range of topics versus one topic area. The boxed in task forces are recommended as being the most informative and helpful.

Clark County, WA
Growing Older in Clark County: Making Clark County a Better Place to Grow Up and Grow Old, Aging Readiness Task Force, February 2012.
http://www.clark.wa.gov/planning/aging/documents/12-0207_ARTF_Plan_Final_Maps_Complete_Print.pdf.

The task force, which consisted of members of the public at large and experts in a variety of fields, concentrated on healthy communities, housing, transportation and mobility, supportive services, and community engagement. The task force focused on creating a livable community defined by AARP as "one that has affordable and appropriate housing, supportive community features and services, and adequate mobility options, which together facilitate personal independence and the engagement of residents in civic and social life."

Colorado
Colorado's State Plan on Aging, Governor John Hickenlooper, Department of Human Services, and Division of Aging and Adult Services, October 2011-September 2015
http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22SUA-StatePlanOnAging-2012-2015.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251774324162&ssbinary=true.

Colorado's State Plan's purpose is to provide a blueprint to increase organizational capacity in accordance with the Older Americans Act. The State Plan was created to fulfill Colorado's responsibilities to the Administration on Aging and to indicate future state activities, outcomes, and strategies.

Dane County, WI
Task Force on the Aging of Dane County, Area Agency on Aging of Dane County, March 2003
http://pdf.countyofdane.com/humanservices/aging/aging_task_force.pdf.

The task force was appointed by County Executive Kathleen Falk with the purpose of analyzing the implications and impact of increased longevity and a growing senior population. The task force was

Prepared by: Megan Mulvihill
Public Affairs Intern
Office of Program Research
House of Representatives

charged with making recommendations to guide the County's response to the challenge of serving an aging population.

Hawaii
Hawaii State Plan on Aging, Executive Office on Aging, October 2011-September 2015.
http://www.hawaiiadrc.org/Portals/_AgencySite/State%20Plan_Final_AOAapproved_9_27_11.pdf.

The State Plan describes Hawaii's goals and strategies to ensure that long-term supports and strategies of older adults and individuals with disabilities, and their caregivers, are met. The State Plan was created for the U.S. Administration on Aging in accordance with the Older Americans Act.

Maturing of America
Maturing of America: Getting Communities on Track for an Aging Population, National Association of Area Agencies on Aging in partnership with the International City/County Management Association, National Association of Counties, National League of Cities and Partners for Livable Communities and funded by the MetLife Foundation.
http://www.n4a.org/pdf/MOAFinalReport.pdf.

The project surveyed 10,000 local governments to determine their aging readiness to provide programs and services to older adults and their caregivers, to ensure their communities are livable for all persons, and to harness the talents, wisdom, and experience of older adults to contribute to the community at large. The report then made recommendations based on those survey findings for the following areas: health, nutrition, exercise, transportation, public safety/emergency services, housing, taxation and finance, workforce development, civic engagement/volunteer opportunities, aging/human services, and policies/guidelines.

Orange County, NC
Orange County Master Aging Plan: Goals, Objectives and Strategies, Orange County Department on Aging, 2012-2017
http://www.co.orange.nc.us/aging/documents/FinalMAP4.20.12.pdf.

The Master Aging Plan is meant to comprehensively address the quality of life and health issues faced by the county's aging citizens, cover a wide range of topics from transportation to housing, and promote equity and diversity throughout the county.

Oregon
Governor's Task Force on the Future of Services to Seniors and People with Disabilities, Department of Human Services: Seniors and People with Disabilities, September 2002,
http://www.oregon.gov/dhs/spd/pubs/gtf/gtf_final.pdf.

Oregon is ranked tenth in the country for number of people over the age of 65, and they are projected to rank fourth in 10 years. The task force focused on the overarching issue of unprecedented demand for long-term care services. The task force recommended a cultural shift which included promoting personal responsibility for healthy behavior choices and preparing for future retirement; planning and sustainable growth in the housing, care, and services sectors; and financing achieved through a public-private partnership.

Below are the task forces that were devoted to a specific topic area. Those which are recommended as being informative and most helpful are boxed in for reference.

Aging of the American Workforce

Report of the Taskforce on the Aging of the American Workforce, Interagency Taskforce headed by the Department of Labor, February 2008
http://www.aging.senate.gov/letters/agingworkforcetaskforcereport.pdf.

The task force was created to address the challenges that an aging and retiring population has on the U.S. labor market including possible labor and skill shortages. The interagency task force's purpose was to identify these challenges and present workforce opportunities for the aging population. The task force focused on three main areas: (1) Employer response to the aging workforce, (2) Individual opportunities for employment, and (3) Legal and regulatory issues regarding work and retirement.

California

California Active Aging Network based on Marin County Task Force Model on Strength Training for Seniors, Established September 1996.
http://www.caactivecommunities.org/our-projects/california-active-aging-network/.

There are 31 California Active Aging Network task forces throughout California. They work to increase the number of Californians over the age of 50 that engage in daily physical exercise. These task forces use the California Active Communities' program model to implement community-based physical activity programs to improve strength, balance, mobility, functional fitness, and to reduce the risk of chronic disease and falls among older adults.

Center for Housing Policy

Housing an Aging Population: Are We Prepared? Center for Housing Policy, 2012
http://www.nhc.org/media/files/AgingReport2012.pdf.

The report examines the housing situation of older adults and the future implications of an aging population on housing. The report provides a detailed analysis of data from the American Housing Survey from the age group 65 and up and provides some final recommendations for handling housing issues for older adults.

Community Action Plan

The Williamsburg Community Action Plan on Aging: 2010-2020, A Report to the Senior Services Coalition of Williamsburg, Virginia, The Center for Excellence in Aging and Geriatric Health.
http://www.seniorservicescoalition.com/docs/CAPOA_Report.pdf.

The Community Action Plan establishes goals, strategies, and action steps to be implemented to ensure a more livable community for seniors. The plan included a needs assessment, demographic data, compilation of current community services and resources, and gathering input from the community via forums. Four priority areas were focused on as a result of the forums: (1) Awareness of and access to resources, (2) vulnerable seniors, (3) housing and neighborhood support, and (4) seniors as a resource.

Connecticut
Report of the Task Force to Study Aging in Place, Connecticut General Assembly, January 2013
http://www.cga.ct.gov/coa/pdfs/AginginPlaceTF/Aging%20In%20Place%20Task%20Force%20FINAL%20report.pdf.

The Aging in Place Task Force was established to address issues associated with infrastructure and transportation improvements, zoning changes, enhanced nutrition programs, improve fraud and abuse protection, expand home medical care options, tax incentives, and incentives for private insurance to help meet the needs to residents who wish to age in place.

Michigan
The Governor's Task Force on Elder Abuse, Michigan Office of Services to the Aging, August 2006.
http://www.michigan.gov/documents/miseniors/GovTaskForce_186155_7.pdf.

Governor Jennifer Granholm appointed the task force to meet between 2005 and 2006 to examine elder abuse issues and "identify new resources, best practices, and necessary changes in law and policies to assist in the prevention of elder abuse."

Minnesota
Reshaping Long-Term Care in Minnesota, State of Minnesota: Long-Term Care Task Force, January 2001
http://www.leg.state.mn.us/docs/pre2003/other/010126.pdf.

The long-term care task force was comprised of Minnesota legislators and state agency commissioners that met to address the states long-term care issues and develop strategies for handling those issues. Minnesota saw their increasing need for long-term care because the state had the second longest life expectancy and one of the highest proportions of persons age 85 and over in the country.

Snohomish County
Creating an Aging-Friendly Snohomish County, A five part series, Snohomish Health District
Series I. Voices from the Community: Focus Groups, July 2011
http://www.snohd.org/Shd_HS/Reports/FocusGrpSummary_Final.pdf.
Series II. Voices from the Community: Key Informants, November 2011,
http://www.snohd.org/Shd_HS/Reports/FinalKIReport.pdf.
Series III. Demographics of the Aging Population, April 2012
http://www.snohd.org/shd_hs/reports/finalelderlydemoreport.pdf.

This is a five part series conducted by the Health Statistics and Assessment Program at the Snohomish Health District in collaboration with the Senior Consortium of Snohomish County. The purpose of the series is to identify and understand the aging population within Snohomish County to define local priorities and identify gaps in social services. The series was completed with focus groups, health surveys, key informant interviews, and population-based data bases. Part four will include health care access data and part five will be population-based health data which have not yet been released.

Washington
Task Force on Long-Term Care Financing & Chronic Care Management, January 2008

Not available in electronic format. Please see the Office of Program Research for the hard copy.

Concerned that the number of Washingtonians aged 65 and older is set to double in the next twenty years, and a younger disabled population accounting for 37 percent of the population, the Washington State Legislature directed the task force to improve the state's ability to support the delivery of long-term care services that meet the current and future needs of Washington's citizens. The task force looked at advance planning and access to long-term care information, aging in place, support for informal caregivers, long-term care financing, chronic care, falls prevention, and health information technology.

DSHS:
Long Term Care

Presentation to the
Joint Legislative Executive Committee
on Planning for Aging & Disability Issues

September 25, 2013

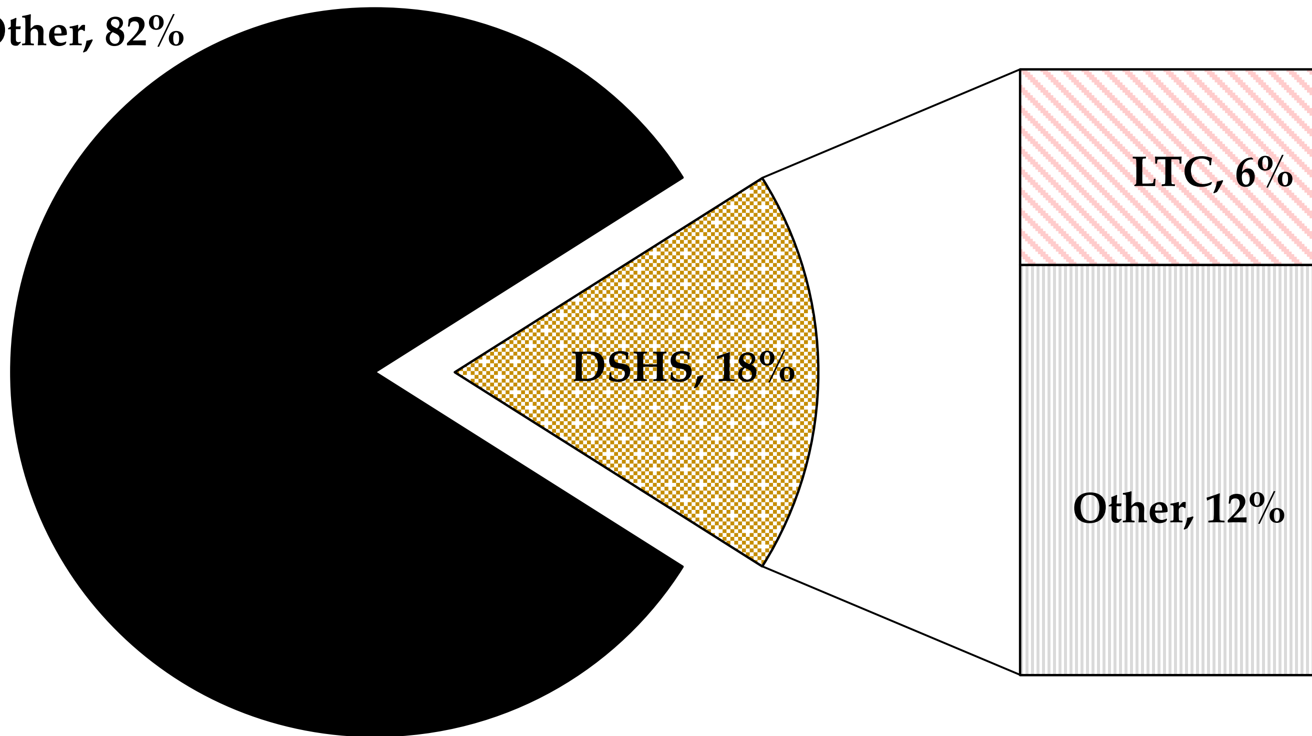
James Kettel, OPR
Carma Matti-Jackson, SCS
Ryan Black, OFM

2013-15 Long Term Care (LTC) operating budget*

$1.8 billion GF-State, $3.8 billion total funds

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

LTC represents about 6% of WA State's general fund



**2013-15 Biennium*
including the 2013-15 Biennial Budget

90% of the LTC budget* pays for client services…

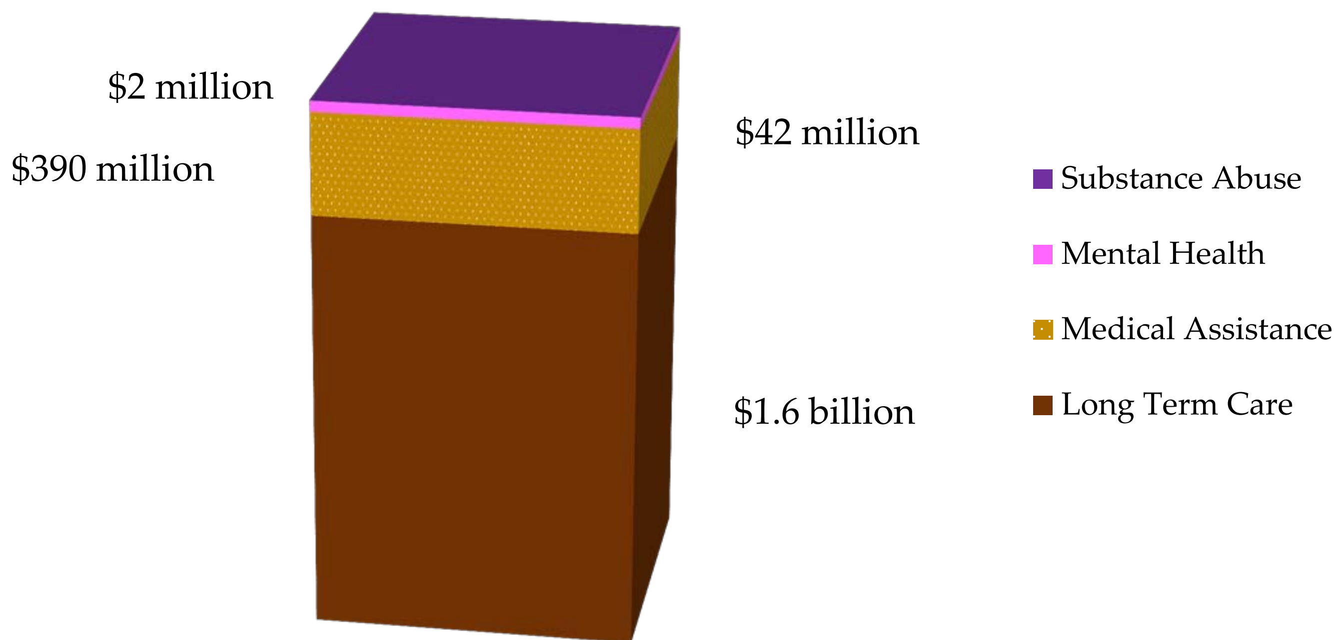
…just over half the budget pays for personal care

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

**2013-15 Biennium including the 2013-15 Biennial Budget*

Just over $2 billion in total funds are spent each year on DSHS and HCA services for the aging

Joint Legislative Executive Committee on Planning for Aging & Disability Issues



**Fiscal Year 2011; dollars in millions; total funds*
- Data for LTC comes from AFRS, Month-of-Payment;
- All other data comes from Research & Data Analysis, DSHS

The LTC budget has consistently grown…

…but, slower growth in recent biennia

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Washington has invested in home and community based services

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Millions

$1,800
$1,600
$1,400
$1,200
$1,000
$800
$600
$400
$200
$-

FY 90
FY 95
FY 00
FY 05
FY10
FY15

In-Home

Community Residential

Nursing Homes

The LTC caseload has consistently shifted…

….toward community services

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

The average monthly cost per client by service setting

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0

$4,411
Nursing Facility
$1,640
Residential
$1,491
In-Home

FY95 96 97 98 99 00 01 02 03 04 05 06 07 08 09 10 11 12 13

Caseloads compared to expenditures

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

The population over 65 has doubled since 1980

…projected to more than double by 2040*

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Washington Population
(65 and over)

**Office of Financial Management November 2012 Population Forecast*

Is the demand for LTC services likely to increase?

*…projecting the LTC caseload through 2040**

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

**this projection is for illustration purposed only; this is not an official forecast from the Caseload Forecast Council.*

Is the budget for LTC services likely to increase?

*…projecting the cost of LTC services through 2040**

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

**this projection is for illustration purposed only; this is not an official forecast from the Department of Social & Health Services.*

DSHS: Long Term Care

Service Overview

James Kettel, OPR
Carma Matti-Jackson, SCS
Ryan Black, OFM

Adult Family Homes

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Service Summary

- A residential home where *no more than six adults* receive personal care, special care, room, and board. Service providers may not be related by blood or marriage to any clients in the home.
- 2013-15 Budget: about $280 million total ($140 Near GF-S) to serve about 5,900 clients.
- About 2,900 licensed facilities in FY13.
- About 17,000 beds in FY13 – about 40% Medicaid.

Service Overview

- Rate methodology established in contract and in WAC.
- Rates are client specific.
- Rates are dependent on location (King, MSA, non-MSA).
- Rates are dependent on client acuity (17 levels of care).
- Client acuity is determined by a CARE assessment.
- Daily payment rate; range from about $50/day to about $165/day.
- Wages and benefits for AFH are collectively bargained.
- Licensure and oversight provided by Residential Care Services (RCS) within DSHS.
- Annual license fee of $225/bed starting in FY14.
- Providers are reimbursed for annual license fees paid on Medicaid beds.
- Processing fee for new applicants of $2,750 in FY13; non-refundable and non-reimbursed.
- AFH serves both LTC & DD clients…about 80% LTC and 20% DD.

Adult Residential Care

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Service Summary

- A residential home where *more than six adults* receive personal care, special care, room, and board. Service providers may not be related by blood or marriage to any clients in the home.
- 2013-15 Budget: about $64 million total ($32 Near GF-S) to serve about 2,200 clients.

Service Overview

- Rate methodology established in WAC.
- Rates are client specific.
- Rates are dependent on location (King, MSA, non-MSA).
- Rates are dependent on client acuity (17 levels of care).
- Client acuity is determined by a CARE assessment.
- Daily payment rate; range from about $45/day to about $160/day.
- Licensure and oversight provided by Residential Care Services (RCS) within DSHS.
- Annual license fee increased from $79/bed to $106/bed in 2010 Supplemental Budget.
- Providers are reimbursed for annual license fees paid on Medicaid beds.
- ARC serves both LTC & DD clients…about 95% LTC and 5% DD.

Assisted Living

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Service Summary

- A residential home where *more than six adults* receive personal care, special care, room, and board. Most clients live in an apartment, or a room similar to an apartment. Service providers may not be related by blood or marriage to any clients in the home.
- 2013-15 Budget: about $115 million total ($59 Near GF-S) to serve about 4,700 clients

Service Overview

- Rate methodology established in WAC.
- Rates are client specific.
- Rates are dependent on location (King, MSA, non-MSA).
- Rates are dependent on client acuity (17 levels of care - from low (A-low) to high (E-high)).
- Facilities with at least 60% Medicaid clients qualify for a rate add-on (the capital add-on).
- About 20% of facilities qualify for the capital add-on.
- Client acuity is determined by a CARE assessment.
- Daily payment rate; range from about $45/day to about $160/day.
- Licensure and oversight provided by Residential Care Services (RCS) within DSHS.
- Annual license fee increased from $79/bed to current $106/bed in 2010 Supplemental Budget.
- Providers are reimbursed for annual license fees paid on Medicaid beds.
- Unlike other settings…assisted living serves LTC clients…no DD clients.

Personal Care: In Home

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

<u>Service Summary</u>

- An *individual provider* is a person working under contract with DSHS, who acts at the direction of a DSHS client living in his or her own home and provides that client with personal care and/or respite care (for DD clients). *Agency provider* refers to a licensed home care agency, or a licensed home health agency, having a contract to provide personal care services to a client in his, or her, own home.
- 2013-15 Budget (IP) = about $1 billion total ($500 Near GF-S) to serve about 27,000 clients
- 2013-15 Budget (AP) = about $600 million total ($300 Near GF-S) to serve about 11,900 clients

<u>Service Overview</u>

- IP…client manages employer functions (i.e. hiring, reporting, scheduling).
- AP…agency manages employer functions.
- Wages and benefits for IP are collectively bargained.
- Wages for IP are based on seniority - from $10.03/hr to $11.07/hr in FY13.
- Change to IP are automatically applied to vendor rate for AP.
- Providers caring for a family member must be an IP.
- Total hourly payment rate; roughly $15/hr for IP and $20/hr for AP.
- Total hourly payment rate is fully-loaded…including $2.21/hr for health benefits in FY13.
- Rate methodology established in the IP contract and in RCW 74.39A.310 (for AP parity)
- CARE assessment used to determine hours of service.
- Service hour authorization depends on client acuity and presence of informal support.
- Service hours range from less than 20/month to about 400/month.
- Average service hours in FY12 were just over 100/month.
- Clients are segmented by acuity (17 levels of care – from low (A-low) to high (E-high)
- IP serves both LTC & DD clients…about 75% LTC and 25% DD.
- AP serves both LTC & DD clients…about 85% LTC and 15% DD.

Nursing Homes

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Service Summary

- Facilities certified to provide skilled nursing services; may be a nursing home, hospital, veterans home, or residential habilitation center
- 2013-15 Budget: about $1.1 billion total ($500 million Near GF-S) to serve about 10,000 clients
- About 220 licensed nursing facilities in FY13
- About 17,000 licensed beds in FY13; about 60% of beds are Medicaid

Service Overview

- Rate methodology established in statute – RCW 74.46
- Rates are facility specific; each facility has one unique rate.
- Rates dependent on case mix, minimum occupancy requirements, lids on allowable costs.
- Rates components are rebased; capital every year, and non-capital every other year.
- Some rate components are recalculated every six months and settled.
- The "budget dial" is the statewide weighted average daily rate; approximately $170/day in FY13.
- There is a proportionate rate reduction to all facilities if budget dial exceeded.
- 2011 Legislature created skilled nursing facility safety net assessment (SNA) and trust fund.
- Some providers exempt from SNA, some pay $1/bed/day, others pay about $13/bed/day
- Providers are reimbursed for SNA paid on Medicaid beds.
- Methodology for the SNA established in statute – RCW 74.48
- Licensure and oversight provided by Residential Care Services (RCS) within DSHS.
- Annual license fee raised from $275/bed to $327/bed in the 2010 Supplemental Budget.
- Providers are reimbursed for annual license fees paid on Medicaid beds.

PACE

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Service Summary

- Program of All-inclusive Care for the Elderly (PACE) providers develop an individualized plan of care integrating long-term care, medical services, mental health services, and alcohol and substance abuse treatment services.
- 2013-15 Budget: about $21 million total ($10 Near GF-S) to serve about 500 clients

Service Overview

- Providence Health System operates the PACE program in WA, called ElderPlace.
- PACE clients must visit the ElderPlace Center, located in Seattle, on a regular basis to meet with a team of specialists (from the medical and social services fields).
- Eligibility Criteria
  - To enroll in PACE, you must either:
    - *be 55 years-old (or older) <u>and</u> be either blind, or disabled*
    - *be 65 years-old, or older*
  - You must require nursing facility level of care.
  - You must live within the designated service area of the PACE provider.
    - *The service area for ElderPlace includes most of King County.*
  - You must meet financial eligibility requirements.
  - You must not be enrolled in any other Medicare, or Medicaid, prepayment plan.
  - You must agree to receive services exclusively through the PACE provider (and the PACE provider's network of contracted providers).

WMIP

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Service Summary

- Washington Medicaid Integration Partnership (WMIP) develops an individualized plan of care integrating long-term care, medical services, mental health services, and alcohol and substance abuse treatment services. Common long term care services include care coordination, personal care, adult day services, environmental modification, and home delivered meals.
- 2013-15 Budget: about $20 million total ($10 Near GF-S) to serve about 400 clients

Service Overview

- WMIP is a managed care program; currently only available within Snohomish County
- Clients may receive one (or more) of the following long-term care services:
- To enroll in WMIP, you must:
  - be aged, blind, or disabled
  - be 21 years-old, or older
  - receive, or be eligible to receive, categorically needy medical assistance
  - not be enrolled in a comparable insurance plan
- To receive long-term care services, you must:
  - meet functional eligibility (as described in 388-106-0210, 388-106-0310, or 388-106-0355)
  - meet financial eligibility (as described in 388-513 and 388-515-1505)
- Eligibility for long-term care services will be determined at least annually.
- Clients ineligible for long-term care services may continue to receive medical, mental health, and/or chemical dependency services through WMIP.

Adult Day Health

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Service Summary

- 2013-15 Budget: about $21 million total ($10 Near GF-S) to serve about 1,100 clients

Service Overview

- Clients receive services , on average about 10 days per month, within an adult day health center

- An adult day health center must offer and provide on site the following services:

  (1) All core services offered under WAC 388-71-0706 - including (a) assistance with activities of daily living, (b) social services on a consultation basis, (c) routine health monitoring, (d) general therapeutic activities, (e) general health education, (f) a nutritional meal and snacks every four hours, (g) supervision and/or protection if needed for client safety; (h) assistance with arranging transportation to and from the program; and (i) first aid and provisions for obtaining or providing care in an emergency.

  (2) Skilled nursing services other than routine health monitoring with nurse consultation;

  (3) At least one of the following skilled therapy services: physical therapy, occupational therapy, or speech-language pathology or audiology.

  (4) Psychological or counseling services, including assessing for psycho-social therapy need, dementia, abuse or neglect, and alcohol or drug abuse; making appropriate referrals; and providing brief, intermittent supportive counseling.

- Rates are paid on a daily basis and are dependent on location
  - Just over $70/day for King County
  - Just less than $70/day for MSA
  - Just less than $65/day for non-MSA

Private Duty Nursing

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Service Summary

- Skilled nursing care for individuals living in community settings whose medical needs cannot be met through other community services. PDN is an alternative to institutional care in a hospital, or nursing facility. Clients receive at least four continuous hours of skilled nursing care on a daily basis.
- 2013-15 Budget: about $32 million total ($16 Near GF-S) to serve about 120 clients

Service Overview

- Rates are paid on an hourly basis.
  - *The hourly rate varies based on provider type (RN, LPN, or IP)*
  - *The range is between about $27/hr and $35/hr, as of July 2012*
  - *Workers may receive holiday pay, ranging from about $10/hr to $12/hr*

- Clients can receive PDN and personal care services.
  - *However, PDN hours are deducted from personal care hours (i.e., one hour from the available hours for each hour of PDN, authorized per WAC 388-106-1030).*
  - *PDN hours may not be scheduled during the same time that personal care hours are being provided by an individual provider, or home care agency provider.*

- The PDN provider is responsible for providing assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL), unless there is an informal support providing or assisting at the same time.

Family Caregiver Support Program

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Service Summary

- Helps unpaid caregivers sustain ongoing caregiving activities, as well as maintain their own mental and physical health.
- 2013-15 Budget: about $26 million GF-S total to serve about 8,000 families per year

Service Overview

Step 1: Information & Assistance

- Caregivers receive information, community referrals, up to $250/year for services

Step 2: Screening (using Tailored Caregiver Assessment and Referral (TCARE) intervention)

- Caregivers receive information, community referrals, up to $500/year for services
- Classified as high, medium, or low for following areas:
  - *Depression* – caregiving creates irritability, persistent sadness, worthlessness, etc.
  - *Relationship burden* – care receiver behavior perceived as demanding, manipulative, etc.
  - *Objective burden* – caregiving forces a change in life patterns (i.e. less time for yourself)
  - *Stress burden* – measure of extent that caregiving created nervousness, hopelessness, etc.
  - *Identity discrepancy* – caregiving creates disconnect between old and new identity

Step 3: Assessment (using TCARE intervention)

- Caregivers receive information, community referrals, average of $2,000/year for services
- Eligibility for assessment is based on screening:
  - *Prior to FY12…qualify with at least four "high" scores*
  - *After FY12 expansion…qualify with one "high" and at least three "medium" scores*
- Recommends evidence-based support unique to each caregiver's situation…such as: support groups, caregiver training and education (increasing skill building and self-care), counseling, respite care services, and supplemental services (such as bath bars and incontinent supplies)

SCSA & Volunteer Services

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Service Summary

- 2013-15 Budget (SCSA) = about $17 million GF-State
- 2013-15 Budget (Volunteer Services) = about $4 million GF-State

Service Overview

- **Senior Citizens Services Act (SCSA)** provides state only community based services for people who need, but are not eligible for paid services. Common services include information/assistance, transportation, counseling, personal care, and nutritional assistance. Some services, such as nutritional services and health screening, are provided at no cost (regardless of client income). Clients may be required to contribute toward the cost of other services depending on a financial assessment.

- **Volunteer Services** is a state-funded program which assists people who need but are not eligible for paid services. Includes assistance with housework, laundry, shopping, cooking, moving, minor home repair, yard care, limited personal care, monitoring and transportation. About 30,000 older adults receive about 288,000 hours of services each year. There are two volunteer service areas in Washington offered through Catholic Community Services and Northwest Regional Council Area Agency on Aging.

Kinship Programs

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Service Summary

- 2013-15 Budget (Kinship Caregivers): about $2 million GF-State
- 2013-15 Budget (Kinship Navigator): about $1 million GF-State

Service Overview

- The Kinship Caregivers Support Program supports for families who are not involved with the child welfare system. Provides about $300 per child to relatives who are at risk of not being able to continue caregiving without additional financial support. Most common use of funding are basic needs like clothing and food (82%), school and youth activities (5%), transportation (5%), legal services (4%). In FY11, the program served about 3,300 children and 2,100 grandparents (and other caregivers).

- The Kinship Navigator Program provides resources, information, and assistance to caregivers who are often overwhelmed and do not know where to turn or how to apply for benefits and services. In FY11, the program provided about 13,400 navigation and assistance services to about 2,000 grandparents (and other caregivers) raising about 3,100 children.

Area Agencies on Aging

Service Overview

Joint Legislative Executive Committee on Planning for Aging & Disability Issues

Service Summary

- 2013-15 Budget (AAA Case Management) = about $118 million total ($58 million Near GF-S)
- 2013-15 Budget (AAA Coordinated Services) = about $93 million total ($47 million Near GF-S)

Service Overview

- AAAs were established under the Older Americans Act
  - Created to help older adults (60 or older) remain in their home
  - AAAs are located throughout the United States
  - AAAs are available to residents within every county of Washington State
  - There are 13 AAAs in Washington.
- AAA's help older adults plan and find care, services, or programs. AAAs also provide support and services to the family or friends caring for older adults.
- Staff at the AAA may help an individual:
  - find services or programs (e.g. transportation, meals, housekeeping, personal care);
  - explore options for paying for long term care and review eligibility for benefits;
  - figure out health care insurance and prescription drug options;
  - find a listing of local adult housing and assisted living; and
  - review legal issues (e.g. advance directives, wills) or make referrals for legal advice.
- AAAs provide ongoing case management for clients receiving in home personal care.
- AAAs coordinate services provided through the Family Caregiver Support Program, Kinship Programs, Senior Citizens Services Act, and Older Americans Act.

Long Term Services and Supports in Washington State: Population Forecasts and Client Characteristics

Presented to the Joint Legislative and Executive Committee on Aging and Disability

David Mancuso, PhD
Research and Data Analysis Division
Washington State Department of Social and Health Services
SEPTEMBER 25, 2013

ALTSA LTSS service population forecast to increase 91% by 2040

Forecast of monthly combined in-home personal care, community residential and nursing facility caseloads

120,000
100,000
80,000
60,000
40,000
20,000
0

Age Wave Analysis

Informal CFC Estimate

Total LTC Actuals
Including June 2013 Forecast

7/1/2010 7/1/2011 7/1/2012 7/1/2013 7/1/2014 7/1/2015 7/1/2016 7/1/2017 7/1/2018 7/1/2019 7/1/2020 7/1/2021 7/1/2022 7/1/2023 7/1/2024 7/1/2025 7/1/2026 7/1/2027 7/1/2028 7/1/2029 7/1/2030 7/1/2031 7/1/2032 7/1/2033 7/1/2034 7/1/2035 7/1/2036 7/1/2037 7/1/2038 7/1/2039 7/1/2040

ALTSA LTSS service population forecast by age . . .

Forecast of monthly combined in-home personal care, community residential and nursing facility caseloads

40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0

Age 85+
Age 80-84
Age 18-59
Age 75-79
Age 70-74
Age 65-69
Age 60-64

7/1/2010 7/1/2011 7/1/2012 7/1/2013 7/1/2014 7/1/2015 7/1/2016 7/1/2017 7/1/2018 7/1/2019 7/1/2020 7/1/2021 7/1/2022 7/1/2023 7/1/2024 7/1/2025 7/1/2026 7/1/2027 7/1/2028 7/1/2029 7/1/2030 7/1/2031 7/1/2032 7/1/2033 7/1/2034 7/1/2035 7/1/2036 7/1/2037 7/1/2038 7/1/2039 7/1/2040

More elders will need support for physical disabilities

Source: "Age Wave" Analysis

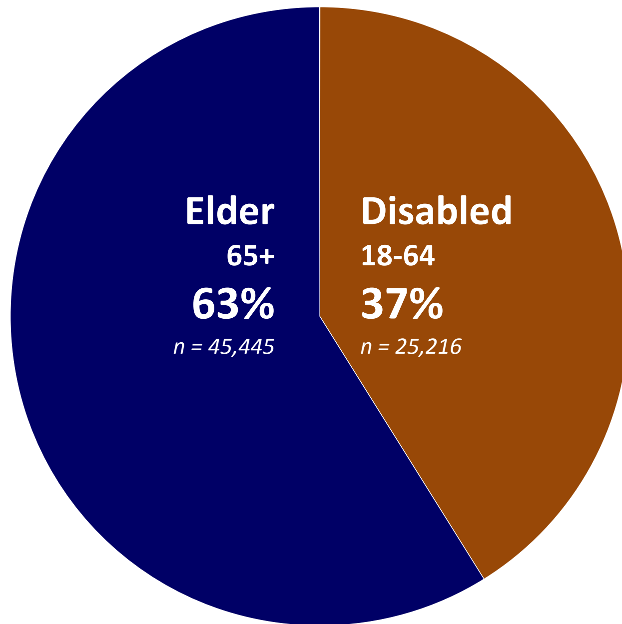
More elders will need support for cognitive impairments

Source: "Age Wave" Analysis

Washington State ALTSA LTSS Recipients

Client Distribution by Type of Medicaid Coverage

SFY 2011 TOTAL = 70,661



Demographics

SFY 2011

	Elder		Disabled	
AGE *As of June 2011*	**TOTAL**	**PERCENT**	**TOTAL**	**PERCENT**
Less than 18	0	0.0%	14	0.0%
18 – 24 years	0	0.0%	607	2.4%
25 – 34 years	0	0.0%	1,506	6.0%
35 – 44 years	0	0.0%	2,850	11.3%
45 – 54 years	0	0.0%	7,420	29.4%
55 – 64 years	0	0.0%	12,814	50.8%
65 – 74 years	12,673	27.9%	0	0.0%
75 – 84 years	16,265	35.8%	0	0.0%
85 and older	16,507	36.3%	0	0.0%
GENDER				
Male	12,907	28.4%	10,373	41.1%
Female	32,538	71.6%	14,838	58.9%
RACE | ETHNICITY				
Asian	6,474	14.2%	1,876	7.4%
African American	1,997	4.4%	2,744	10.9%
Hispanic	2,512	5.5%	1,635	6.5%
American Indian	1,255	2.8%	1,950	7.7%
Other	4,176	9.2%	2,992	11.9%
White	37,243	82.0%	21,352	84.7%

NOTES: The disabled category includes a small proportion of clients who are not enrolled in disability-related Medicaid coverage. The small proportion of disabled clients who were age 65 or above as of June 2011 are represented in the 55-64 age group.

Pharmacy Risk Factor Profiles

Persons receiving LTSS services in SFY 2011

THERAPY CLASS	SUMMARY DRUG DESCRIPTIONS	Elders Percent	Disabled Percent
Cardiac	Ace inhibitors, beta blockers, nitrates	77.3%	62.1%
Depression/Anxiety	Antidepressants, antianxiety	54.8%	67.4%
Pain	Narcotics	49.6%	65.1%
Hyperlipidemia	Antihyperlipidemics	45.3%	38.3%
Diabetes	Insulin, sulfonylureas	28.8%	30.5%
Asthma/COPD	Inhaled glucocorticoids, bronchodilators	26.7%	35.5%
Seizure disorders	Anticonvulsants	21.0%	40.5%
Psychotic Illness/Bipolar	Antipsychotics, lithium	18.9%	25.4%
Alzheimer's	Tacrine	13.9%	1.8%
Multiple Sclerosis/Paralysis	Baclofen	8.8%	31.3%

SOURCE: RDA Integrated Client Database

Diagnosis Risk Factor Profile

Persons receiving LTSS services in SFY 2011

		Elders	Disabled
THERAPY CLASS	SAMPLE DIAGNOSIS	Percent	Percent
Cardiovascular, very high	Heart transplant status/complications	1.4%	3.4%
Cardiovascular, medium	Congestive heart failure, cardiomyopathy	31.5%	17.8%
Cardiovascular, low	Endocardial disease, myocardial infarction, angina	28.9%	21.5%
Cardiovascular, extra low	Hypertension	22.3%	24.1%
Diabetes, type 1 high	Type 1 diabetes with renal manifestations/coma	0.4%	1.6%
Diabetes, type 1 medium	Type 1 diabetes without complications	7.1%	9.6%
Diabetes, type 2 medium	Type 2 or unspecified diabetes with complications	10.5%	9.7%
Diabetes, type 2 low	Type 2 or unspecified diabetes without complications	23.2%	19.0%
Psychiatric, high	Schizophrenia	7.6%	12.6%
Psychiatric, medium	Bipolar affective disorder	6.3%	9.7%
Psychiatric, medium low	Major recurrent depression	12.1%	21.0%
Psychiatric, low	Other depression, panic disorder, dementia	25.7%	15.5%
Substance abuse	Alcohol or other drug abuse or dependence	6.3%	26.1%

SOURCE: RDA Integrated Client Database

Diagnosis Risk Factor Profile

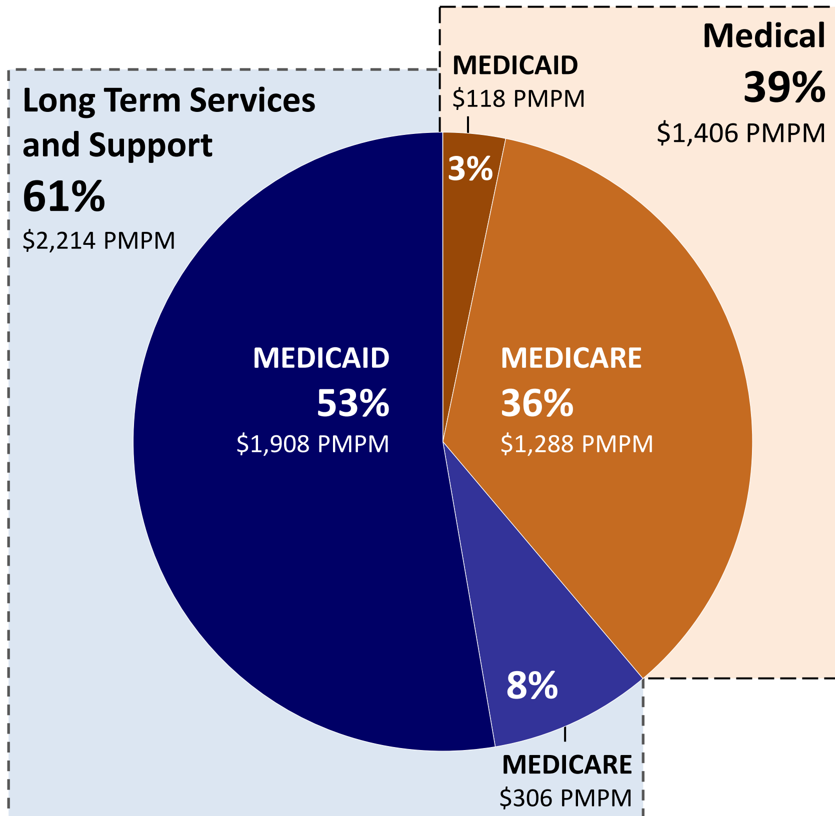
Persons receiving LTSS services in SFY 2011

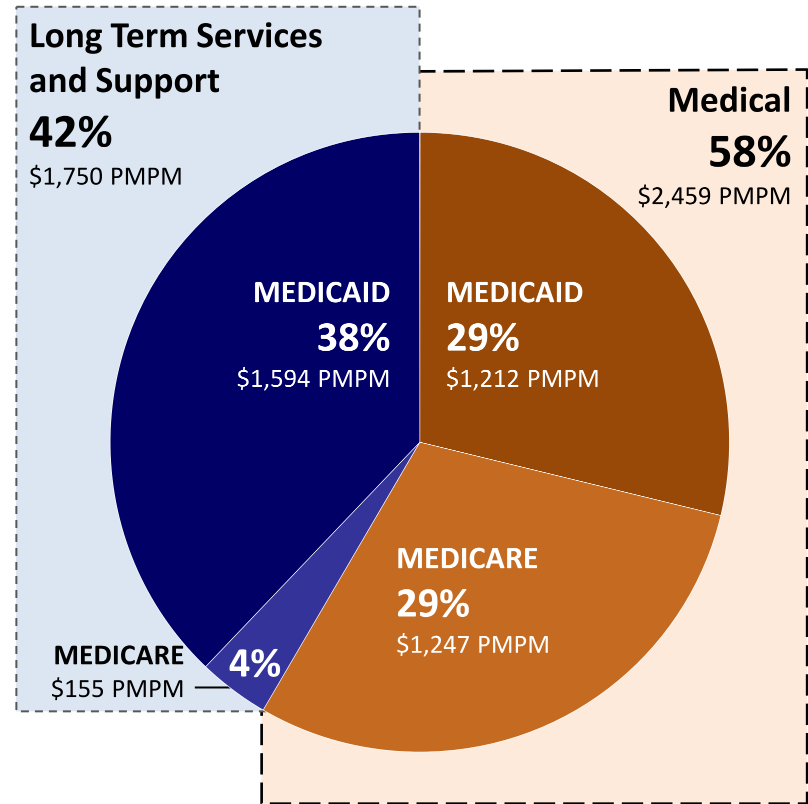
THERAPY CLASS	SAMPLE DIAGNOSIS	Elders Percent	Disabled Percent
Pulmonary, very high	Cystic fibrosis, lung transplant, tracheostomy status	4.4%	6.2%
Pulmonary, high	Respiratory arrest or failure, primary pulmonary hypertension	1.1%	1.2%
Pulmonary, medium	Other bacterial pneumonias, chronic obstructive asthma	18.7%	18.7%
Pulmonary, low	Viral pneumonias, chronic bronchitis, asthma, COPD	21.4%	21.8%
Renal, very high	Chronic renal failure, kidney transplant status/complications	18.5%	10.5%
Skeletal, medium	Chronic osteomyelitis, aseptic necrosis of bone	13.6%	18.2%
Skeletal, low	Rheumatoid arthritis, osteomyelitis, systemic lupus	22.6%	19.6%
Skeletal, very low	Osteoporosis, musculoskeletal anomalies	8.5%	10.0%
Skin, high	Decubitus ulcer	8.5%	8.9%
Skin, low	Other chronic ulcer of skin	5.0%	6.1%

SOURCE: RDA Integrated Client Database

Medicaid and Medicare Medical and LTSS Expenditures

Persons receiving LTSS services in SFY 2011





SOURCE: RDA Integrated Client Database

Medicaid and Medicare Medical and LTSS Expenditures

Persons receiving LTSS services in SFY 2011

	Total Costs		PMPM Costs	
	ELDER	DISABLED	ELDER	DISABLED
TOTAL MEDICAL COST	**$662,191,722**	**$679,467,386**	**$1,406**	**$2,459**
Medicaid	$55,632,344	$334,794,120	$118	$1,212
Medicare *(Part D imputed)*	$606,559,378	$344,673,266	$1,288	$1,247
TOTAL LONG TERM SUPPORTS AND SERVICES*	**$1,042,598,804**	**$483,543,257**	**$2,214**	**$1,750**
In-home	$353,939,994	$273,847,290	$752	$991
Adult Family Home	$71,099,096	$34,299,985	$151	$124
Adult Residential Center	$21,974,530	$7,978,917	$47	$29
Assisted Living	$47,399,756	$10,702,249	$101	$39
Nursing Home – Medicaid	$404,106,317	$113,772,598	$858	$412
Nursing Home – Medicare	$144,079,111	$42,942,218	$306	$155
GRAND TOTAL (Medical + LTSS)	**$1,704,790,526**	**$1,163,010,643**	**$3,621**	**$4,209**

*Medicaid + Medicare

SOURCE: RDA Integrated Client Database

Questions?

Department of Social and Health Services
Aging and Long Term Support Administration
Inventory of Resources

Presented to the Joint Legislative/Executive Committee on Aging and Disability

Bea Rector, Director
Home and Community Services Division
SEPTEMBER 25, 2013

What will DSHS emphasize for the future?

Controlling costs by:

- Continuing the shift to home and community-based services that allow as much independence as possible
- Providing more information and supports to family caregivers that helps avoid or delay the need for Medicaid-funded long-term services
- Joining with Health Care Authority to:
  - Increase the number of people with high medical risks receiving health home services
  - Increase the number of people receiving coordinated services through Medicare and Medicaid

Maintaining safety by:

- Timely response to allegations of abuse and neglect and complaints about provider practices

Continuing the shift to home and community-based services—progress to date

Year	LTSS Caseload	Number in Community	Percent in Community	Number in Nursing Homes	Percent in Nursing Homes
1995	36,141	19,496	54%	16,645	46%
2005	47,600	35,515	75%	12,085	25%
2015*	62,220	52,428	84%	9,792	16%

* Based on CFC informal estimates

Continuing the shift to home and community-based services—where do we want to go?

- Under Governor Inslee's Results Washington goals we are accountable to increase the percent of supported seniors and individuals with a disability served in home and community-based settings to 87.2% by June 30, 2015
- Continuing that trend will be one of the keys to sustaining long-term services into the future
- To do that effectively we will need to:
  - Continue to adjust the HCBS service package in response to shifts in the population (for example, improving supports for people with dementia as the average age of the LTSS population increases)
  - Work with the nursing home industry to continue to shift its role toward stabilization and rehabilitation, followed by discharge to supported community care
- Increase the number of people we are able to relocate from nursing homes to their home or other community-based setting

Supporting people of all acuity levels in community-based settings has been key

Long Term Care Assessment by Setting and Acuity

HIGHER

- **GROUP 1.** Extremely limited ADLs, often immobile
- **GROUP 2.** Very limited ADLs, plus cognitive problems
- **GROUP 3.** Moderately limited ADL, plus clinically complex
- **GROUP 4.** Moderately limited ADL and/or behavior challenge
- **GROUP 5.** Moderately limited ADL

Setting	Group 1	Group 2	Group 3	Group 4	Group 5
Adult Family Home	1,421	2,494	844	843	697
Assisted Living	16	366	551	911	3,306
Adult Residential Center/EARC	97	380	291	519	850
Agency	308	2,079	2,980	3,121	3,506
Individual Provider	1,293	7,621	6,976	5,249	3,722

8,000
6,000
4,000
2,000
0

Avoiding the need for Medicaid-funded long-term services—interrupting the path is critical

- The number of people on the Medicaid LTSS caseload is only a small share of a very large number of seniors and people with disabilities, who, were it not for help from family and friends, could become part of the Medicaid caseload
- Over 850,000 Washington State citizens are unpaid family caregivers who provide 80% of the services needed to allow family members to remain at home for as long as possible.
- About a fourth of them provide that care on a full time basis.
- The path to Medicaid is common and predictable:

STEP ONE: **Someone has a need for care**

STEP TWO: **Family caregivers become exhausted**

STEP THREE: **Out of pocket spending exhausts financial resources**

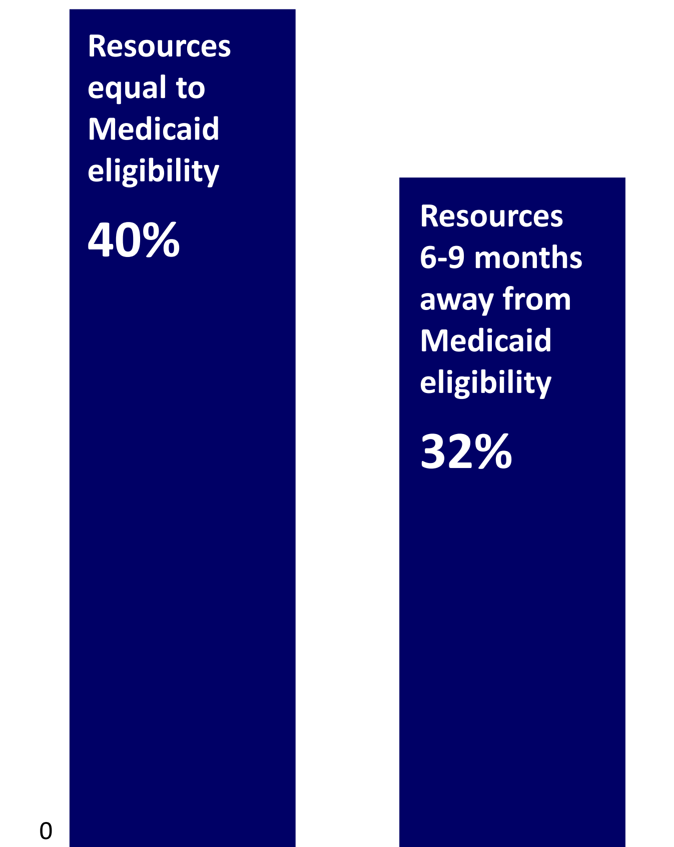
STEP FOUR: **Medicaid**

Avoiding the need for Medicaid-funded long-term services—where are we now?

- In FY2013, Washington's Family Caregiver Support (FCSP) program provided 8,600 unpaid family caregivers with:
  - Education and training
  - Consultation
  - Counseling
  - Access to support groups
  - Respite care
- A recent preliminary study by the Washington State Institute for Public Policy (WSIPP) showed that FCSP produced statistically significant delays in demand for Medicaid funded services
- FCSP has been shown to reduce caregiver stress, depression and the caregiver's difficulty adjusting to their role

Avoiding the need for Medicaid-funded long-term services—where do we want to go?

- Simply put, we need to reach more people ***before*** their resources are exhausted and they must turn to the state
- That means more information and counseling on how to extend their financial resources and more supports for family caregivers that extends their ability to provide care
- A sample of 1,440 FCSP cases shows how important that is since many would financially qualify for the Medicaid long-term services



Maintaining safety—as caseloads have grown, so have the allegations of abuse and neglect

- 22% increase in APS caseload from FY11 to FY13
- 6% growth is projected for FY14 and FY15

Adult Protective Services (APS) Caseload

1,500
1,200
900
600
300
0
879
Actual
Projected
1,572
Jul-05 Jul-06 Jul-07 Jul-08 Jul-09 Jul-10 Jul-11 Jul-12 Jul-13 Jul-14 Jul-15

Data Source: APS_Snapshot_caseload for EMIS. The caseload data represents the unique count of clients who have an APS case assigned counted by their intake date.

Maintaining safety requires timely investigation of allegations of abuse and neglect

- Under Governor Inslee's Results Washington goals we are accountable to decrease the number of vulnerable adult abuse and neglect investigations left open longer that 90 days to 12.05% by June 30, 2015

Percent of Adult Protective Services investigations open longer than 90 days

Questions?

Washington State Health Care Authority

Joint Legislative Executive Committee on Aging and Disability

Health Care Authority Initiatives

MaryAnne Lindeblad, HCA Medicaid Director

September 25, 2013

Washington State Medicaid Challenges

- Medicaid delivery system silos
  - *Managed care, fee-for-service*
  - *County-based behavioral health*
  - *Dual-eligibles (Medicare & Medicaid)*
  - *Long-term services and supports*
- Fragmented service delivery & lack of overall accountability
- Service needs and risk factors overlap in high-risk populations
- Incentives and reimbursement structures not aligned to achieve outcomes

Medicaid Initiatives

- Three major cross administration initiatives:
  - *Transition blind and disabled populations into managed care*
  - *Health Homes*
  - *Duals Strategies (Medicare & Medicaid)*
- Initiatives designed to provide integrated and coordinated care for clients served by State programs
- Focus on high-risk populations and clients with complex care needs

Transition Blind and Disabled Populations into Managed Care

- To promote coordination of care for Medicaid enrollees, HCA has transitioned Medicaid populations from fee-for-service to coverage by a Healthy Options health plan.
- Phased in enrollment into managed care for disabled and blind populations began July 2012
- Program evaluation is under way as part of the 1915b waiver evaluation.

Health Homes

Goals:

- Person-centered health action goals to improve health, health-related outcomes
- Coordinate across the full continuum of services and ensure care transitions
- Facilitate delivery of evidence-based health care services
- Increase self-management of health goals
- Single point of contact responsible to bridge systems of care

Health Homes

- Health homes are a natural vehicle to align delivery of care and provide an array of care coordination activities based on client need.
- Primary care health homes and community-based health homes (mental health centers, aging networks, other community providers).
- Managed care plan Health Home requirements began in July 2013; Health Homes for FFS clients rolled out July 1 through October 2013.
- Increased federal financing and state match enhancement will be used to leverage FFS health home individuals.

Duals Strategies

- Collaborative effort by DSHS and HCA to design innovative care models for individuals eligible for both Medicare and Medicaid.
- Washington one of 15 participating states.
- Seeks shared savings with Medicare, but real goal to improve care.

- **Strategy 1**: Health homes, enhanced integration and coordination of care, began mid-2013.

- **Strategy 2**: Full managed care benefit package integrated care pilots in King and Snohomish Counties to begin in 2014.
  - *Three way contract with CMS*
  - *Two participating plans: Regence and United*

Washington State Health Care Authority

Does the State Health Care Innovation Plan Have the Potential to Influence Improvements?

- Reduce "Medicaid delivery system silos"
  - *The state plan is being developed to focus on payment reform and a whole-person approach to care that mitigates silos and connects physical and behavioral health, with a goal of improving the long-term health outcomes of Washingtonians at reduced cost*
  - *Reducing the number of chronically ill through better health outcomes has the potential to reduce the amount of Medicaid services needed as our state's population ages*
- Reduce "fragmented service delivery" & "improve accountability"
  - *The state plan is being developed in part to reduce fragmentation and to improve accountability*

For More Information:

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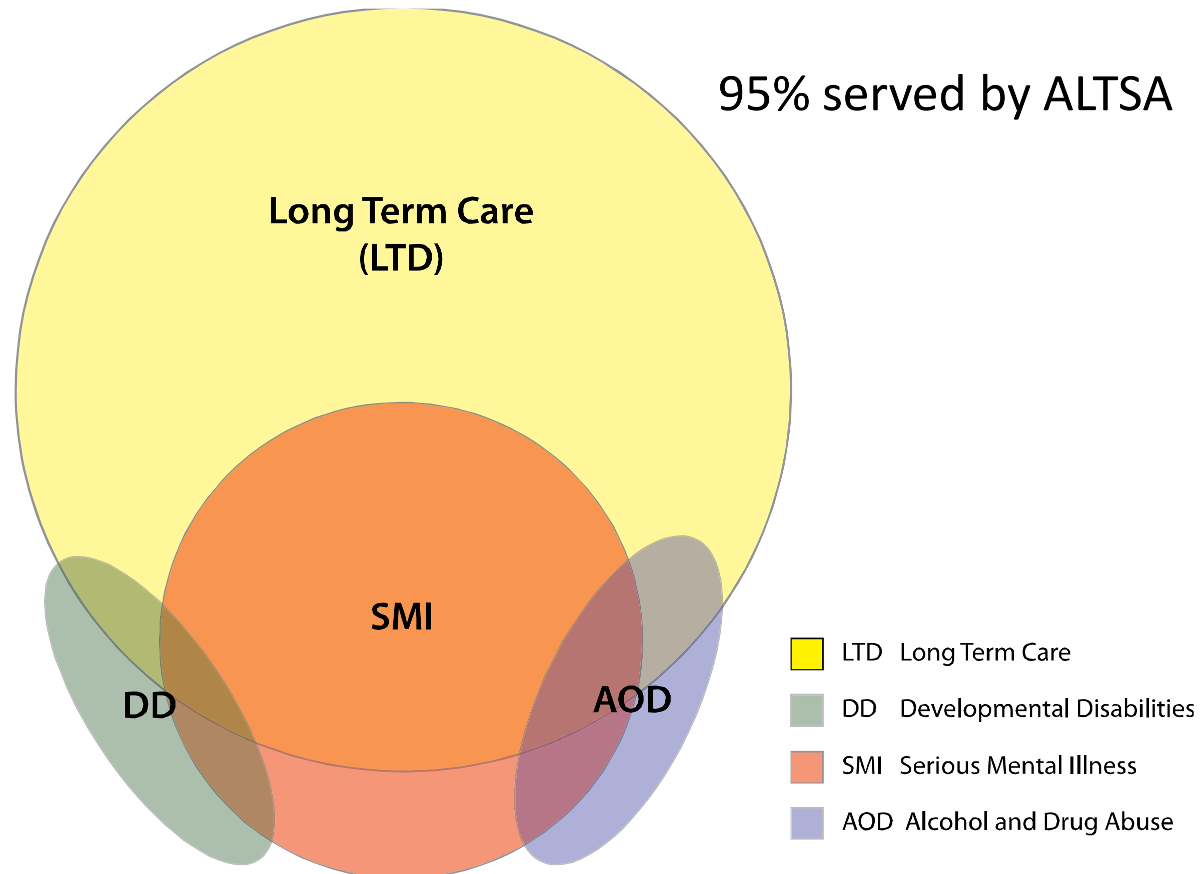
Health Homes and Duals Financial Alignment projects

June 21, 2012

Health Homes

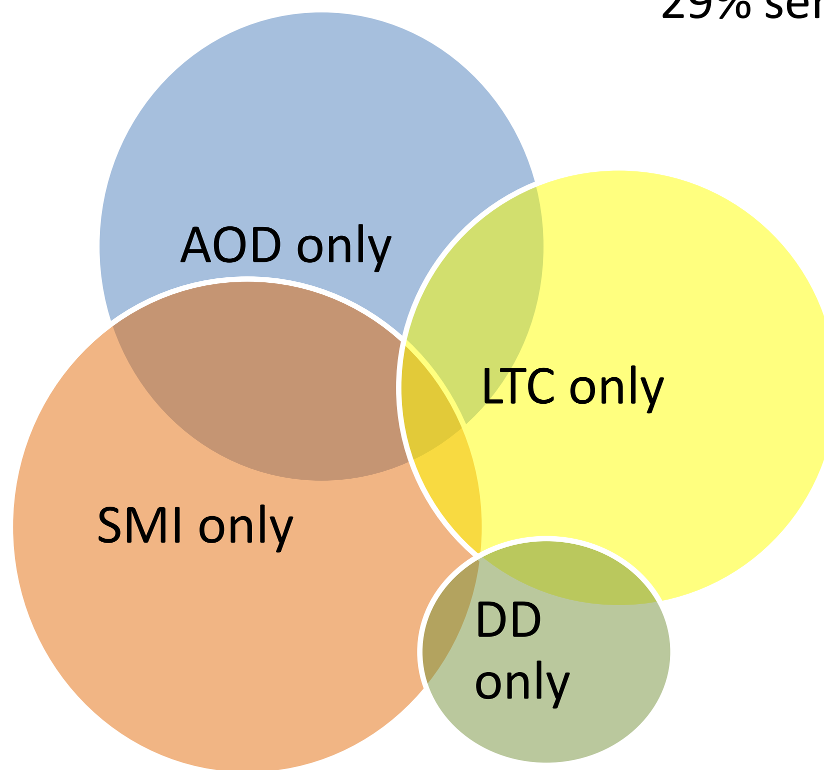
Why Bother?

Service Needs Overlap for High Risk/High Cost Beneficiaries who are Eligible for Medicare & Medicaid



Service Needs for High Risk/High Cost Medicaid-Only Beneficiaries Overlap

29% served by ALTSA



HealthPath Washington
Washington State Health Care Authority
Washington State Department of Social & Health Services

Managed Fee-For-Service

How does it fit in?

Washington State Health Care Authority

Department of Social & Health Services

Managed FFS (MFFS) Financial Alignment Demonstration

- Health homes are a natural vehicle for aligning the delivery of care in the FFS population
- Grant Funding from CMS supports state infrastructure

HealthPath Washington

Washington State Health Care Authority

Benefits

- Structure already in place through State Plan Amendment
- Potential to sustain the program after 90/10 match can no longer be claimed
- Ability to add additional resources through the use of infrastructure grants
- Coordinated services bridges the existing fee-for-service system
- Access the right care, at the right time and place

Challenges

- Different rules, different measures, more resources needed
- Agreement and signatures on the Final Demonstration Agreement
- Agreement and signatures on the State Plan Amendment
- Communication challenges
- Delays in funding
- Performance Measures

HealthPath Washington

Washington State Health Care Authority

Washington State Department of Social & Health Services

Health Homes

Implementation Approach

June 21, 2012

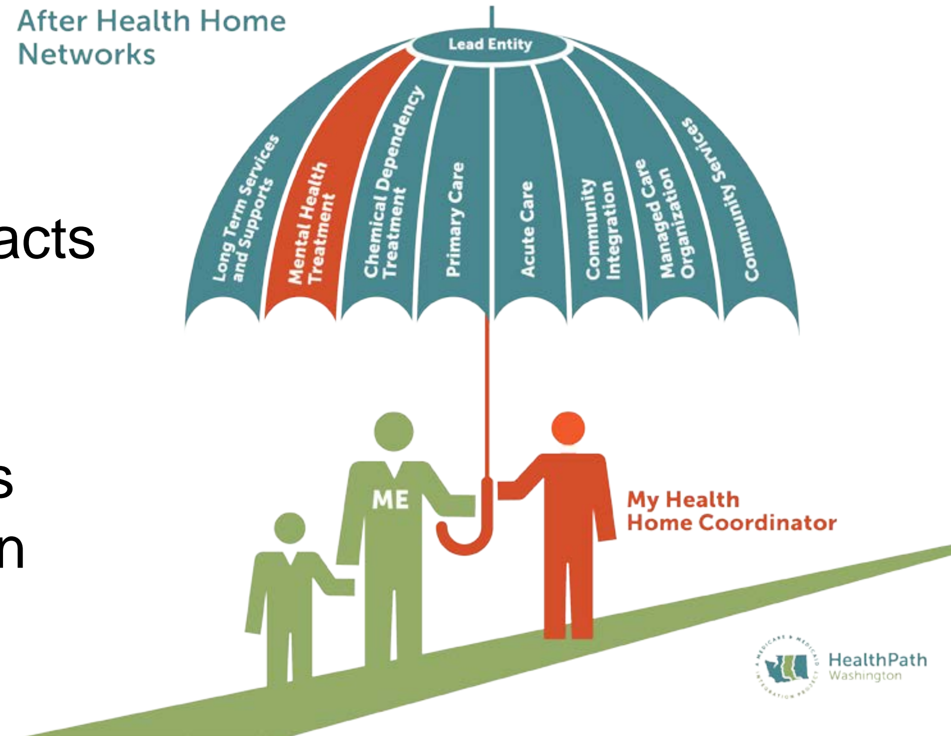
Washington State Health Care Authority

Goals

- Establish person-centered health action goals designed to improve health, health-related outcomes and reduce avoidable costs
- Coordinate across the full continuum of services
- Organize and facilitate the delivery of evidence-based health care services
- Ensure coordination and care transitions
- Increase confidence and skills for self-management of health goals
- Single point of contact responsible to bridge systems of care

Focus on High Risk Enrollees

- Most at-risk for adverse health outcomes
- Greatest ability to achieve impacts on hospital and institutional utilization, and mortality
- Most likely to need/receive multiple Medicaid paid services
- Cost effective / achieve a return on investment
- Need to achieve funding sustainability for these interventions

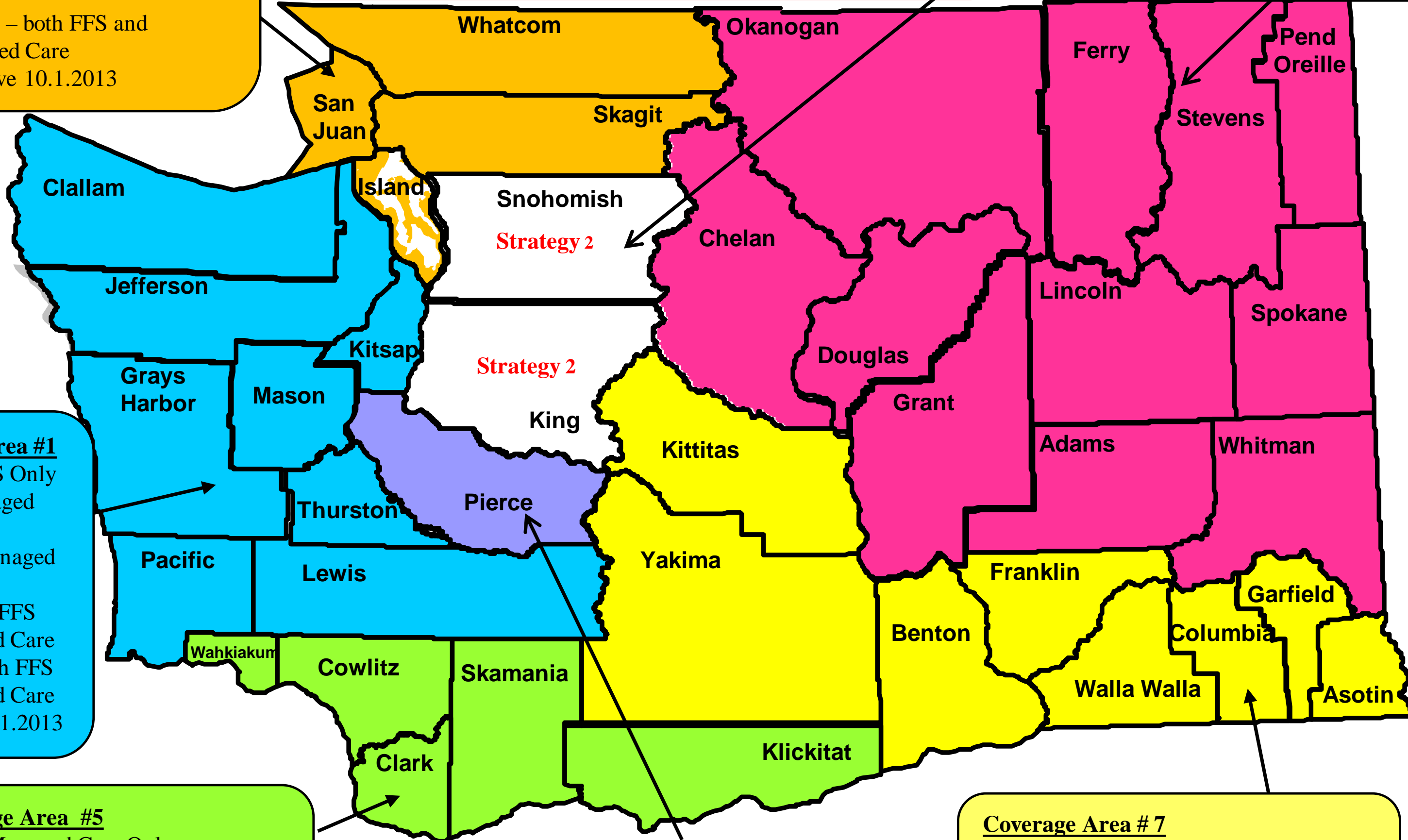


Health Home Coverage Areas

Strategy 2 – Medicare/Medicaid Integration Project (Managed Care)
Regence Blue Shield and UnitedHealthCare
Voluntary Enrollment 5.1.2014 and Passive Enrollment 7.1.2014

Coverage Area #2
NWRC – FFS Only
CCC – Managed Care Only
Molina – Managed Care Only
UHC – both FFS and Managed Care
CHPW – both FFS and Managed Care
Effective 10.1.2013

Coverage Area # 6
Community Choice – FFS only
CCC – Managed Care Only
Molina – Managed Care Only
UHC – both FFS and Managed Care
CHPW – both FFS and Managed Care
Effective 10.1.2013



Coverage Area #1
Optum – FFS Only
CCC – Managed Care Only
Molina – Managed Care Only
UHC – both FFS and Managed Care
CHPW – both FFS and Managed Care
Effective 10.1.2013

Coverage Area #5
CCC - Managed Care Only
CHPW & UHC - both Managed Care and FFS
OPTUM - FFS Only
Effective 7.1.2013

Coverage Area #4
CCC & CHPW - Managed Care Only
UHC - both Managed Care & FFS
Optum - FFS Only
Effective 7.1.2013

Coverage Area # 7
CCC & CHPW - Managed Care Only
UHC – Managed Care and FFS
OPTUM & SE WA ALTC - FFS Only
Effective 7.1.2013

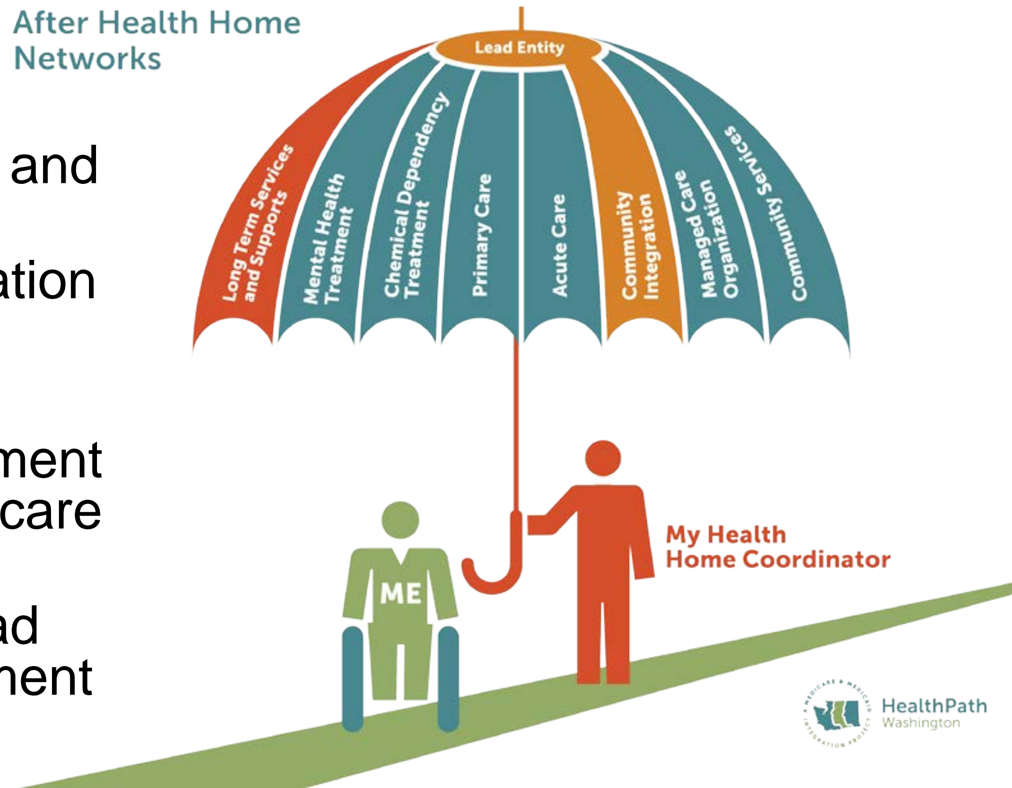
6/25/2013 REV

Qualification Process

- An application and process developed for 3 phase roll-out to qualified health homes
- Released in November 2012, February 2013 and May 2013.
- Emphasis on creation of community partnerships, expert care coordination staff, outreach and high touch services delivered in community setting including a beneficiary's home

Payment for Health Home Services

- $252 for outreach, engagement and health action plan
- $172 for intensive care coordination services;
- $67 for maintenance
- Health plans pass share of payment to network entities who provide care coordination services
- Fee-for-service: Payment to lead entity that passes share of payment to entities who provide care coordination services



Washington's Math to fund FFS health homes

- Increased Federal financing for first 8 quarters
- State financing current match will be enhanced by 40%
- The added match will be used to leverage FFS HH individuals

Next Steps

- 2nd Health Home SPA submitted for October 1, 2013 start dates for remaining coverage areas
- Finish readiness reviews and on-site visits for new Qualified Leads
- Train Care Coordinators
- Sign contracts
- Enroll eligible population into Qualified Leads
- Take a deep breath and
- Continue to work on Strategy 2, 3-way Capitated/Integration Management Care

Duals Financial Alignment Demonstration –Apple Advantage

- Managed Care in Snohomish and King Counties
- Integrated services
- Medicare/Medicaid full dual population
- 3-way contract with CMS
- Two health plans – Regence and United

MOU and 3-way Contract

- MOU currently written but not approved yet
- MOU is high-level agreement of operational aspects
- Mid-October approval date for MOU
- 3-way Contract at CMS to be merged with Medicare template
- November/December approval date

Next Steps

- Rate development
- Readiness reviews
- Marketing material
- P1 system changes to support program

Resources

Websites: http://www.hca.wa.gov/health_homes.html
http://www.adsa.dshs.wa.gov/duals/
http://www.integratedcareresourcecenter.com/

Becky McAninch-Dake – Becky.McAninch-Dake@hca.wa.gov
Karen Fitzharris – Fitzhkm@dshs.wa.gov
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Governor Inslee's Aging Summit

October 1st, 2013

Recommended Pre-Reads and Resources

Top-Line Recommended Pre-Reads

Talkn' bout My Generation: What makes the boomers the boomers? By Neil Howe, *Governing Magazine,* September 2012.
http://www.governing.com/generations/government-management/gov-what-makes-boomers.html

How Boomers, Millennials and Immigrants Are Changing America. By Peter Harkness, *Governing Magazine, May 2013*
http://www.governing.com/columns/potomac-chronicle/col-boomers-millennials-immigrants-changing-america.html

Creating Communities that Support Healthy Aging. By Nancy LeaMond, Executive Vice President, Policy and Practice, April 2013.
http://states.aarp.org/wp-content/uploads/2013/09/Creating-Communities-That-Support-Healthy-Aging.pdf

In a Graying Population, Business Opportunity by Natasha Singer, Feb 5, 2011, New York Times
http://www.nytimes.com/2011/02/06/business/06aging.html?pagewanted=all&_r=1&

Research Highlights in the Demography and Economics of Aging, Helping Americans Age in Place, May 2013 http://agingcenters.org/docs/rh13_Helping-Americans-Age-In-Place_2013.pdf

2014 Washington State Aging Agenda by AARP Washington
http://states.aarp.org/wp-content/uploads/2013/09/2014-Washington-State-Aging-Agenda.pdf

The Big Idea in 4 Minutes, Coming of Age in Aging America, video by Vitalpictures, 2012.
http://www.youtube.com/watch?v=ZOA1v4-2Fos

Readying for Retirement
Everett Herald Op-Ed, 6/22/2013 by Senator Barbara Bailey and Representative Steve Tharinger.
http://www.heraldnet.com/article/20130622/OPINION03/706229977

Facts and Fictions about an Aging America by the MacArthur Foundation Research Network on an Aging Society, Fall 2009
http://www.macfound.org/media/files/AGING-CONTEXTS-FACTFICTION.PDF

Resources by Topic

Livable Communities

Livable Community Indicators for Sustainable Aging in Place, Metlife Mature Market Institute. https://www.metlife.com/assets/cao/mmi/publications/highlights/mmi-livable-communities-highlights.pdf

Aging in Place: A State Survey of Livability Policies and Practices
by: Nicholas Farber, Douglas Shinkle - National Conference of State Legislatures, Jana Lynott, Wendy Fox-Grage, Rodney Harrell, from: Public Policy Institute, December, 2011
http://www.aarp.org/home-garden/livable-communities/info-11-2011/Aging-In-Place.html

Transportation Funding Reform: Equity Considerations for Older Americans
by: Jana Lynott, Sandra Rosenbloom, PhD, University of Arizona, from: Public Policy Institute, December 2011
http://www.aarp.org/home-garden/transportation/info-12-2011/transportation-funding-reform.html

Planning Complete Streets for an Aging America
by: Jana Lynott, Amanda Taylor, Hannah Twaddell, Jessica Haase, Kristin Nelson, Jared Ulmer, Barbara McCann, Edward R. Stollof, from: Public Policy Institute, May 2009
http://www.aarp.org/home-garden/livable-communities/info-08 2009/Planning_Complete_Streets_for_an_Aging_America.html

Loss of Housing Affordability Threatens Financial Stability for Older Middle-Class Adults by Rodney Harrell, PhD and Shannon G. Guzman, from: Public Policy Institute, January 2013
http://www.aarp.org/research/ppi/security/loss-of-housing-affordability-threatens-financial-stability-for-older-middle-income-AARP-ppi-sec/

Growing Older in Clark County: Making Clark County a better place to grow up and grow old. Prepared by the Aging Readiness Task Force and Clark County Community Planning Staff, February 2012.
http://www.clark.wa.gov/planning/aging/documents/12-0207_ARTF_Plan_Final_Maps_Complete_Print.pdf

Financial Security

Elders Living on the Edge, When Basic Needs Exceed Income in Washington, Wider Opportunities for Women, Washington Area Agencies on Aging, 2011.
http://www.wowonline.org/documents/WAPolicyBrief.pdf

Not Making the Grade: 2013 Survey Of Financial Decisions Among Washington State Adults Ages 45-64
by: Brittne Nelson, AARP Research & Strategic Analysis, from: AARP Research, April 2013
http://www.aarp.org/work/retirement-planning/info-04-2013/not-making-the-grade--2013-survey-of-financial-decisions-among-w.html

The Retirement Savings Crisis: Is It Worse Than We Think? National Institute on Retirement Security, June, 2013. http://www.nirsonline.org/index.php?option=com_content&task=view&id=768&Itemid=48

At Leisure, Or Still at Work, New York Times article by Steven Greenhouse, September 9, 2013 http://www.nytimes.com/2013/09/10/business/retirementspecial/at-leisure-or-still-at-work.html?_r=0

Elder Justice: National Strategy Needed to Effectively Combat Elder Financial Exploitation, United States Government Accountability Office (GAO), November 2012 http://www.gao.gov/assets/660/650074.pdf

Financial Abuse Costs Elders More Than $2.6 Billion Annually, According to MetLife Mature Market Institute Study http://www.gerontology.vt.edu/docs/MetLife_Fin_Elder_Abuse.pdf

Elder Financial Exploitation: Implications for Future Policy and Research in Elder Mistreatment by Thomas Price, MD, Patricia S King, RN, Rebecca L Dillard, MA, and James J Bulot, PhD' *West J Emerg Med.* 2011 July; 12(3): 354–356. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117613/

Health Care

Washington State Chronic Disease Self-Management Education http://aoa.gov/AoARoot/AoA_Programs/HPW/ARRA/Docs/WA%20Profile%20on%20Template.pdf

Lawmakers are cooking up ways to encourage better eating and cultivating local economies. By Amy Winterfeld, National Conference of State Legislatures, January 2012. http://www.ncsl.org/issues-research/health/the-new-healthy.aspx

State Government Alzheimer's Disease Plans, Alzheimers Association web site http://act.alz.org/site/PageNavigator/state_plans.html

Washington State Alzheimer's Statistics, Alzheimer's Association, Alzheimer's Association. http://www.alz.org/documents_custom/facts_2013/alz_f-fstatesheets-48.pdf?type=interior_map&facts=undefined&facts=facts

Boomers Want Control of Their End-of-Life Care, by Jonathan Walters, Governing Magazine, October 2012. http://www.governing.com/topics/health-human-services/gov-end-of-life-care-control.html

Improving Advanced Illness Care: The Evolution of State POLST Programs by: Naomi Karp - AARP Public Policy Institute, Charles Sabatino - American Bar Association, from: Public Policy Institute, April 2011 http://www.aarp.org/health/doctors-hospitals/info-04-2011/polst-04-11.html

Letting Go: What should Medicine do when it can't save your life? by Atul Gawande, New Yorker, August 2, 2010. http://www.newyorker.com/reporting/2010/08/02/100802fa_fact_gawande

Long-Term Services and Supports

Medicaid: A Program of Last Resort for People Who Need Long-Term Services and Supports by Donald Redfood and Wendy Fox-Grage, AARP Public Policy Institute, May 2013. http://www.aarp.org/health/medicare-insurance/info-05-2013/medicaid-last-resort-AARP-ppi-health.html

The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers
by Donald Redfoot, Lynn Feinberg, Ari Houser, Public Policy Institute, August, 2013
http://www.aarp.org/home-family/caregiving/info-08-2013/the-aging-of-the-baby-boom-and-the-growing-care-gap-AARP-ppi-ltc.html

A Call to Action: What Experts Say Needs to Be Done to Meet the Challenges of Family Caregiving, by Susan c. Reinhard, Lynn Feinberg, and Rita Choula, AARP Public Policy Institute, February
2012. http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/Spotlight-Paper-Meeting-the-Challenges-of-Family-Caregiving-AARP-ppi-ltc.pdf

Long Term Care Reform in Hawaii: Report of the Hawaii Long Term Care Commission, January 18, 2012
http://www.publicpolicycenter.hawaii.edu/documents/HawaiiLTCCFinalReport.pdf

What do you mean I'm getting old? Denial About Aging and Our Impending Long-Term Care Crisis, by Bruce Chernof, MD Perspectives on Aging with Dignity, the SCAN Foundation. http://www.thescanfoundation.org/what-do-you-mean-i%E2%80%99m-getting-old-denial-about-aging-and-our-impending-long-term-care-crisis

Current Issues and Potential Solutions for Addressing America's Long-Term Care Financing Crisis by Gretchen Alkema, The SCAN Foundation, March 2013.
http://www.thescanfoundation.org/sites/thescanfoundation.org/files/tsf_ltc-financing_overview_alkema_3-20-13.pdf